

STATUS AND PROBLEMS OF ELDERLY WOMEN

with special reference to the urban area of Jhansi

Submitted for

Ph.D. Degree in Social Work



By
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M.S.W.

UNDER GUIDANCE
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Bundelkhand University, Jhansi

**BUNDELKHAND UNIVERSITY, JHANSI (U.P.)
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CERTIFICATE

This is to certify that present work entitled "Status and problems of elderly women with special reference to the urban area of Jhansi" has been carried out by Km. Pratibha, under my direct guidance and supervision. Her observation has been checked and verified by me from time to time. She has put in more than 200 days attendance as per rules laid down.

The thesis fulfills the regulations of government for submission of thesis for the degree of Ph.D. in (Social Work) laid down in Ph.D. ordinance of the Bundelkhand University, Jhansi (U.P.).

R.D.-2

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PREFACE

It is an accepted truth that the elderly need more social and health care than medical care. The problems are related with pension, employment subsidy schemes, housing, food clothing, social respect and other provisions. There require concerted and coordinated efforts in almost all sectors such as health, human development and welfare.

Increasing life expectancy and increasing numbers and proportion of the world population represented by older persons, is become a norm today. The older population itself is ageing. The fastest growing aged group in many countries are persons 60 years and older. Let us look at the 75 years period between 1950 and 2025. The world population as a whole will have increased three and half times from 2.5 billion to 8.46 billion. The world population 60 and older however, will increase six fold from 201 million in 1950 to 1.2 billion in 2025. Developments in respect of the 80 plus population are the most astonishing. They will increase ten fold from 13 million to 137 million and health services and the majority will be least able to cope with this new situation.

It is the elderly, who are in focus in this research study. The basis of discussion is the desire of the medical as well as social work profession to do its duty to the elders. The alarming rise in numbers and their being subject to age-related disorders and diseases and being under-employed and later being dependent, non-productive and

even bed-ridden in terminal stage, warrants a careful planning of their total health care at all levels and at all stages of their life.

A number of organizations, both social and professional, have adopted this agenda and are engaged in this humanitarian task to provide relief. But it is a drop in the ocean, looking as they are, to the tip of the iceberg. The problems are hidden. Ego, vanity, shyness or even shame, does not make the aged open their hearts to reveal what they undergo, how shamefully they are treated and how desperate they feel. The law provides for their looking after by their children, but how many invoke this remedy for their social isolation and deprivations, depression, psychiatric aberrations and chronic physical illness.

The pathology is therefore, multiple. It is socially stigmatous. The "honour" or "reputation" forbids the elders to express their total indignation and helplessness social, emotional, economical and physical - the basic components of Health as defined by world Health Organisation.

Care of the old in the families, is in-built in all cultures. The communities have their agenda set to look after the old and the aged. The families must understand their commitment and obligations. It is the moral duty of all to shed their complexes, identify the problems and their causes (on an individual level) and find ways to honour the living rather than the dead, to shower respect on those alive rather than build monuments to remember them.

We, in the developing countries, do not have to be complacent any

more. We have to revive our cultural heritage of respecting the elders and providing them comfort and a better quality of life. It is the duty of the state - yes, but it is as well the responsibility of the families and communities to demonstrate their willingness to help the elderly. The elderly themselves have also to accept and adopt the changing environment and help themselves accordingly. Families are still the best bet and their support is as vital as extrinsic support to the families to fulfil their obligation in their mission of service, respect and love.

One has to distinguish between the "physical" man and the "man" in the man. Mind is the repository of all desires, a storehouse of ambitions and egos , yet blessed with a self evaluating and self assessing mechanism. What it should do is, to sort out the positive responses from the negative ones and then throw off the latter. A self introspection leads to the preventive process becoming active and operational, bringing in its wake, self control, self discipline and self regulation. mental health is subservient thus to spiritual health, which helps to bring in physical, social , emotional and mental well-being i.e. perfect health, as it is defined.

More and more active attention needs to be focused, as a compulsion, on preventive measures on these life style-illnesses, during the ageing phase, to minimize morbidity.

A national effort could, like social security system, provide well for this commitment to the aged. It has now become an urgent necessity, may an urgent compulsion, to utilize the limited national resources

on prevention/blocking the disease process, thereby curbing the requirement of more and more sophisticated institutions. The benefits of what science knows and what medical & social work profession can offer, must effectively reach the elderly population. This research study has in its contents details of the introduction of ageing, its indicator, etc. Simultaneous inclusion of the various problems, issues, rehabilitation aspects, make the move towards comprehensive and meaningful a discussion possible.

Social adjustment is a personal matter in families which need to follow the traditional norms of treating the aged as assets or as guides. They have to be kept in high esteem and given all respect and honour.

The important factor still remains as to how the elders themselves commit and contribute to their own welfare through personalised initiative, planning and organising their own life. Balancing the calm and chaos, the creativity and naturalness, and combining the basic with comfort- all lead to life styles that need wisdom to ease tension, depression and anxiety. This is the message of our effort towards rehabilitation of the elderly to ensure the best quality of life while living and facing death with dignity.

The government has translated its political will and nation's commitment through a comprehensive declaration - The National Policy for Older Persons (1999). This declaration has placed the responsibility for the elderly on all those who are involved in providing health care - socio-economical, psycho-emotional, mental and spiritual and in rehabilitative fields, alongwith education / training of all categories of

elderly cares. Its implementation, as per its contents, is now the main consideration. Help, assistance and co-operation has to be generated as envisaged, by all concerned at all levels to meet the target.

So far as the objectives of this study are concerned they are as follows:-

1. To study socio-demographic features of respondents.
2. To identify social status and social, economical, psychological and physical problems of elderly women.
3. To study the role of family and self care practices by the elderly women.
4. To study the various issues in relation to the elderly women.
5. To seek the opinion of respondents regarding various welfare measures provided by the Government and Non Government Organization.

The contents of the research study is divided into eight chapters which are systematically arranged as follows :-

- 1- First chapter deals with introduction, objectives of the study along with indicators of ageing my this related to aged, National policy for aged and research methodology which had been adopted.
- 2- In the second chapter review of pertinent studies relevant to the topic undertaken in India and out side have been done which have got bearing the present study.
- 3- Chapter third discuss the socio-economic and demographic

characteristics of the respondents problems of the respondents.

4- Fourth chapter identifies social status and socio-economic, psychological and physical problems of the respondents.

5- The fifth chapter discuss them role of family in relation to elderly women along with self care practices performed by the respondents.

6- Chapter sixth deals with the various issues related to elderly.

7- The seventh chapter deals with the opinion of respondents regarding various welfare measures provided by the government and No-government organisations.

8- Chapter eight provides conclusion and suggestions of study.

I express my deep sense of gratitude to my guide Dr. R.P.Nimesh, Lecturer,Dept. of Social Work , Dr. B.R. Ambedkar Institute of Social Sciences ,Bundelkhand University ,Jhansi(U.P.),for his constant inspiration and supervision. Despite of his heavy engagement, he gave ample time, whenever I required for his guidance. He held informal discussions on every aspects of the research work that facilitated the task in many ways. A debt like this hard to paid off in more words .I would remain indebted throughout my life for his intellectual supervision and guidance.

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I cannot forget Dr. Sanjay Bat, Professor in Deptt. of Social Work in Delhi University, Delhi who inspired for research work at the eve of my viva voce when I was student of MSW previous.

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The kind and pleasant personality of Prof. R.B.S. Verma , H.O.D. of J.K. Institute of Social Work , Lucknow University, Lucknow who also inspired me when I was working in Sahbhagi Shiksahn Kendra ,a well known N.G.O. in social work field.

I am too much obliged of my generous parents who provided me freedom to acquire highest level of education.

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I am grateful to Shri Balram, Co-ordinator working in Social Welfare Department, All Indian Institute of Medical Sciences, Delhi

who provided me recent and pertinent literature related to aging.

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Date : August, 2005

Place : JHANSI

Pratibha
(Pratibha)

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CHAPTER-I

- (i) INTRODUCTION
- (ii) OBJECTIVES OF STUDY
- (iii) RESEARCH METHODOLOGY

- Introduction
- Universe of study
- Research design
- Sampling method/size
- Source/Techniques of data collection
- Classification of data
- Tabulation of data
- Analysis and Interpretation of data
- Diagrammatic presentation of data

INTRODUCTION

NEED OF RESEARCH STUDY

Old age is a serious, complicated and universal problem. With the results of changes taken place in the family structure and functions, family is unable to look after and providing security to orphans, widows, widowers and, aged as it used to provide before. It is the reason that today in between of elderly and family a successful adjustment is not possible and the result is that the life of elderly is full problems.

Old age is a obvious and natural state. Therefore problems of ageing are remained in human life from the very begining of the world. In reality old age is a serious and complex problem of human being which comprises tremendous problem of in its aspects. Benjamin Islash highlighted on problems of old age. He says that old age is just like a special disease, by which every individual suffers from it and other diseases also arrest it. In old age several problems - physical, mental, family, community - adjustment, loneliness, isolation, non use of leisure time, less income for nutrition of himself and dependents also captured the old age.

The problem of aging in India is emerging, to some extent, due to the increasing proportion of the aged people in the population, but, to a great extent, owing to the declining roles and status in old age in the changing Indian society (*Desai et al., 1973*)¹. Due to the changing social structure and cultural system following industrilization, urbanization and modernization processes, the life of the aged people has become problematic. since the knowledge and experiences of the aged people are not considered necessary for the proper functioning of the rapidly changing new society, they are sidelined and their needs are neglected. Thus, aging is not a smooth process today, but a painful one, in which the aged are exposed to the vulnerability of the aging process, in the threatening and challenging environment. Owing to the increased importance of achieved properties, increased importance of achieved

1. Desai, K.G. and Naik, R.D. Problems of retired people in Greater Bombay. Tata Institute of Social Sciences, Series No.27, 1973; D'souza, Alfred. The social organization of aging among the urban poor. Social Action, No. 32. Jan.-March, 1982.

properties, and in the absence of any familial support, the aged have to depend on their own resources for the satisfaction of their needs².

It is correct without any debate that the tendency of discardedness of old is increasing in the world. That's why elderly began to helpless.

In the perspective of increasing problems of old age United Nations assembly declared to celebrate year 1991 as a "Elderly year". The hidden objective was to invite the attention of people about the need of implementation socio-cultural and health related programmes for their betterment. At present in every month ten lakh people per month in the world enrolling themselves in the list of old men. In 1950 the old men population was twenty crore. In the light of reducing birth rate and increasing life expectancy the population of 60 plus will be sixty crore in year 2001 and in year 2025 when the population of the world would be 600 crore then the population of olds would also be 120 crore, two times more than the children of the world at that time.

At present elderly are suffering from many physical, mental, social and psychological problems.

Shri Staufer Samuel puts a brief light on the people of this condition with relation to No., percent and decade growth (from 1951 to 1991)³.

Population of person 60+ (In India)in Millions.				
Year	No. of persons	% of the population	Total	Decadal increase in population 60+ growth rate (%)
1951	20.190	5.66	•	..
1961	24.712	5.63	4.522	22.40
1971	32.700	5.97	7.988	32.31
1981	42.172 (a)*	6.49	10.472	31.02
1991	54.685 (b)*	6.54	11.513	26.67
2000	75.696 (b)*	7.63	29.011	38.42

*(a) Excluding Assam
*(b) Projected

2. Mishra S. Coping with Aging at Individual and Societal Levels, Aging. Indian Perspective and global scenario, edited by Dr. Vinod Kumar, AIIMS, New Delhi, 1996, P.P.- 223.

3. Staufer Samuel; Review. A major step of investigation in Social Sciences, American Sociological Review, edition - 23, year - 1962, page - 73.

As well as the National Sample Survey Organisation (N.S.S.O., 1998) pictured the scene of olds in developed countries i.e. based on data of 1989 given in following table⁴.

Facts About the Aged Persons of India (Rural / Urban)			
S.No.	Classification of Aged Persons	Rural	Urban
1.	Persons in lakhs	394.51	87.35
2.	Sex Ratio (No. of females per 1000 males)	675	697
3.	Economically independent	34.02%	28.94%
4.	Gainfully employed	40.55%	26.76%
5.	Living alone	7.99%	5.94%
6.	Williing to shift to the home for the aged	19.10%	17.60%
7.	Having chronic disease	45.00%	44.80%
8.	Physically Immobile	5.40%	5.50%

SOCIAL SIGNIFICANCE OF STUDY

The old women and men are proud and a precious asset of our country, not the burden. They are the producer of our springs. They have a vast reservoir of experience and can contribute positively for the sustence and progress of our society and the nation. The elderly understand the inner meaning of life and they have better perceptions and judgement of human behaviour and inter personal relationship.

Though various studies have been carried out in the country about status of elderly women but this research study highlights on some newer facts. This study is first of its kind which is conducted in Jhansi of U.P. In this study the status and problems of elderly women is identified indepth.

The findings of this study are beneficial in the field of social work for formulating welfare schemes and programmes. It will provide help to various . NGO in respect to their planning while thinking various areas which are left out by the people and important.

4. National sample Survey Organization, Report based on data of 1989, New Delhi - 1990.

The study will help the government to plan the programmes for the upliftment of aged people as they are important part of the society. The study will also be educative to aware the general public, family members and society at large who has been taking no or less interest in aged will accept them as the asset of this society and will make use of their experiences.

This study will invite attention about various problems of aged. The valuable data of this study can be used by social reformers, sociologist, policy makers and state planners who have ambitions to raise the status of elderly women.

The results and findings of this study will inspire the department of medical education to add geriatrics as compulsory subject to be taught to new medical graduates so that they could be able to understand and manage the physical and mental problems at their hospitals and clinics. It is well known proverb that necessity is the need of invention. A trained personnel can better understand the problems, like other cell as Radiology, Pathology , Surgery and Skin Geriatrics Clinic will also be separate to oldmen & women. Geriatric should be included in Primary Health Care because oldmen, women are also valuable group in both urban and rural population.

CONCEPT OF RESEARCH STUDY

Old age is not a disease but a essential condition of human life cycle. It comes and each individual has to suffer from it. Elderly men women status remained high in our Indian culture. Traditional joint family system,social organization and varna system are powerful evidences of it. What type was their social status and how much respect was given to them. It is true without any debate that present individual centralized materialistic culture reduce the power in the form of an 'Actor' so the elderly status is downward effected. In present situations elderly status is isolated and lost its honour. He is unable to adjust in present family social circumstances. It is far away to reap the benefits of their experiences, modern generation does not like to get counseling. What

an unique condition it is! In present situations new generation dislike the ideology. Whenever elders intervene in their living and food habits, they are ignored often by them. Then elders do not tolerate and feel insult and humiliation. Thus cold war is started between elders and youngers. That is called inter generation conflict (IGC). Elders do not like any sort of changes nor able to adjustment because there are following problems before them-(1) Time consuming (2) Family environmental, emotional, physiological health problems (3) Protection of economical property, psychological family adjustment and gratification of needs. While aging is essential part of human biological and cultural process, in which individual develops discarded outlook about his life and feels depression. From sociological points, the problem of aging is the problem of non adjustment with family and society.

There is no single evidence in the history of human society in which all individuals had equal social status. It is because of each individual has different awareness, qualification and skills. According to Elliot and Merrill (1941) status is position which the individual occupies in the group by virtue of his sex, age, family, class, occupation, marriage and achievements⁵. According to Linton, status is place in a particular system which a certain individual occupies at particular time will be referred to as his status with respect to that system. Status is thus either achieved or ascribed. So far as individual role is concerned that is all activities which are performed by any individual in accordance with status⁶.

Richard et.al (1960:4) Problems are behaviour patterns or conditions that are considered objectionable or undesirable by many members of society. These members recognize that the corrective policies, programmes and services are necessary to cope with and reduce the scope of those problems⁷. *Merton R.K (1961:701)* Generally speaking, a social problem can be seen as a significant discrepancy between social standards and social activity⁸. Elderly denotes those women who crossed their

5- Elliot and Merrill (1941 - 9) Social Disorganisation.

6- Linton, The Cultural background of personality, p-264.

7- Richard.C. Fuller and Myers, 'Some aspects of a theory of Social Problems', American Sociology Review (Feb. - 1941) PP-24-32. Also see Weinberg.S. Kirson, Social Problems in our town (1960-4).

8- Merton, R. K. (1961-701) 'Social Problems & Sociological Theory in comtemporary Social Problems.

mensuration period and reach the stage of menupass or 60 plus of age. In this research study the "status and problems of elderly women" means position of 60 plus age of women occupies in her family and facing objectionable or undesirable behaviour patterns or conditions created by members of her family.

WHO IS AGED

Aging is unequivocally an universal and irreversible process. This process varies considerably within and between cultures. Getting old is the result of the interplay of biological, social, psychological and ecological factors. Old age is the last phase of the human life cycle, and the timing of this phase its impact on role relationship and the meaning attached to it vary in different societies and even in different su-groups of a society. In the process of aging, the last phase is considered as decline and death, and in this phase majority of the aged face economic, soical psychlogical dna ehalth problems which of course, vary from individual to individual. Further, the determination of old age differs from society ot society in accordance with the social organisation including the cultural beliefs in vogue on one hand and the level of economy, standard of living and health services on the other.

First of all it is important that we should know who are aged or old or elderly or senile or senior citizens. These words have been used synonymously/interchangeably. The aged is advanced in age or a person who lives longer. According to chambers 20th century dictionary, ageing is the process of growing old or developing qualities of the old, maturity and aged organism. Whereas old is advanced in year having been old or relatively long in existence, senile is a characteristic of an old age, showing the decay of old age. Thus for a lay man, aged is a person who has lived longer thereby suggesting a relative phenomenon. But for utility in life we have to take a particular age as the beginning of old age or aged.

There are some approaches which have been utilized for categorism of aged. These approaches are physiological, psychological, socio-cultural and economic etc. According to *Gray and Moberg (1962)* physiologically

a person is old when the signs of wearing out of the body appears. There is no one age when all physical functions functions of a given individual begin to show a decline. Deterioration of various parts of the body proceeds at different rates and is generally so slow that it cannot be measured accurately at weekly, monthly or even annual intervals. Excepts for certain limited purpose it is therefore not yet practicable to use physical criteria as the basis for determining wheather or not an individual is old⁹."

The 'old'or 'aged' is a relative term and are generally used in relation to young. It is really very difficult to draw a dividing line uniformly for all communities. There are no definite biological or psychological or socio-culture parameters which individually or collectively can democrate the particular chronological age uniformly. Being a relative criteria, it will differ from species to species as the life expectancy, longevity and life span also differ. Even it may vary within the species. The "concept" of aged in man varies with purpose and view point and also with sex, residence, climate etc. The concept will also depend upon people's view point. It varies between urban and rural people. (*Biswas 1987*)¹⁰ Even it is conceived differently by the old, the people look upon old age as a stage characterised by economic insecurity, poor health, loneliness, resistance to age and failing physiologic and mental power. It is however useful to use a single uniform cut off age for the sake of convience. According to *Riley (1972)*¹¹ acute deficits may occur by 60 or may be staved off till 90 and some persons may be largely detached from involvement in the community at 70, while others may remain active well into the 80's¹¹.

There is another approach to get help for delineating the aged i.e. the retirement age. But this remains only for a small number of persons who take some employment from they retire at a particular age. There are so many people who has been taken 60 years of age as cut off point because of two reasons. Firstly, the retirement age in most of the Indian

9. Gray, R. M. & Moberg D. O. *The Church and the Older Person*. William B. E. Publ. Co. Michigan, 1962.

10. Biswas, S. K. *Dependency and family care of the aged in village India; a case study*. In *Ageing in Contemporary India*. ed. by S.K. Biswas. Indian Anthropological Society, Calcutta. pp. 38-57, 1987.

11. Riley, M.W. *Ageing and Society. A Sociology of Age stratification*, Vol. 3. Russel Sage Foundation, Newyork, 1972.

States in Govt. and private institutions lies between 55 and 60 years and secondly, the life expectancy in India is low compared to developed countries. In this context *Guha Roy (1991)* also writes "The definition of old age is very much dependent on its use in a particular context. Way of fixing the entry into old age based retirement however, ignores that large number of women have not been in the gainful occupation and that the age of retirement varies not only between countries but also between public and private sectors within a country¹²."

Ageing is universal. No one escape it and the physical effects are clearly noticeable. Ageing is that state in which the person is unable to take part in any of the working which is important for normal person. One of the key factor for the uncapability to perform work is due to loss of physical and mental capability. For census purposes, a cut-off age of 60 years is taken for classifying people as old in India. Many nations follow this as the cut-off age, while many of the developd nations, including United Nations (1991)¹³, take the cut-off age of 65 years for classifying as old. However it is important to understand that ageing and old age are functional and not chronological concepts. Culture plays a powerful role in defining old age. In Indian context, for example, traditionally one is often considered old when one's eldest child gets married. This cultural aspect has important bearing on when one feels and is perceived by others as old, and this is particularly pertinent for women. In this context it is important to understand that individual ageing depends on prior living conditions and quality of life lived and vary from place to place and person to person (*Sharma, 1993a*)¹⁴.

In the words of Seneca, "Old age is an incurable disease" More recently Sir James Sterling Ross commented that, "you do not heal old age. You protect it, you promote it, you extend it." Old age should be regarded as a normal, inevitable biological phenomenon which gradually approaches towards deaths. Ageing is a process of adaptation by an individual to

12. Guha Roy, S. Ageing of Population - An investigation in Indian Context. In I. J. Prakash. (Ed.) Quality Ageing - Collected papers. Association of Gerontology, Varanasi. pp.196-217, 1991.

13. United Nations. World Population Prospects, 1998. United Nations, New York, 1991

14. Sharma, S.D. Developing curriculam for geriatric medicine. In Bhatla PC.(Ed.).Community Geriatrics: Care of the Elderly-Issues, status, solutions. National Institute of Primary Health Care, New Delhi, pp56-58, 1993a

severe losses of functions in various organs, elasticity of tissues and mind. WHO defined old age as, "The period of life when impairment of mental and physical function becomes increasingly manifest by comparison with previous period of life¹⁵." In India, age of sixty years is considered the dividing line between middle and the old age.

AGEING IN ANCIENT HINDU PRACTICES

Old age has been discussed often in its various aspects in Hindu scriptures inclusive of Vedas, Upanishads and Manusmritis. Following are the extracts from some of the scriptures to explain the perception of Hindus seers and sages about old age.

According to Vedas, old age should be perceived as an event full of optimism instead of the present mood of pessimism, that is due to the fear of impending death, hanging like a sword of Democles. Following Mantras unfold the perception as visualized in Vedas. ***O Lord! Let the elderly, who has been transformed into a pillar of wisdom, experience and maturity and shines like a full moon, be spared from the clutches of death. With your divine grace, he may shine every day like a rising sun to illuminate the world and remove the darkness of ignorance. (Rig Veda)¹⁶.*** Similarly in the following Mantra, God is invoked as follows:- ***May all of you, who are leading a family life as per prevalent customs and traditions with devotion, dedication and sincerity, pass into old age while performing activities, that improve welfare welfare of the community and spreading light towards off darkness (ignorance) in the world ,as these activities in turn,will transform his ageing into a healthier one (Rig Veda)¹⁷.*** Role of social harmony in making ageing healthier has been stressed in the following Mantra. ***Aspire! O Man, you can live by virtuous deeds for a hundred years and in peace with the neighbours (without hatred and jealousy). Thus alone and not otherwise, will you serve your own interest (Yajur Veda)¹⁸.***

15. WHO. International classification of Diseases, Manual of the International Statistical Classification of Diseases, Injuries and Cause of Death, 1967

16. Rig Veda 10/0.59/4

17. Rig Veda 10/18/16.

18. Yajur Veda X / L / 2.

Vedas also define the components of healthy ageing as enunciated in the following Mantra. *By taking inspirations and strength from you, who has all devtas (angels) at his command. I may live for a hundred years, with perfect sight, hearing, speech and normal thinking capacity. May I remain independent (no dependency) for hundred years. Even if my age crosses a hundred years, I may lead a life with all my faculties and senses in tact.* Ways to healthy ageing has been discussed in Charak Samhita(a treatise on Ayurveda) viz. *To enjoy the fruits of old age; you must improve the life style(Achar Rasayan) prescribed as follows:-* (a) *Don'ts:- Abstain from alcohol, anger, and indulgence in excessive sexual activity, violence, cruelty, excessive fatigue-producing activities, narrow-mindedness.* (b) *Do's:- Speak truth, have soft speech, practise meditation, remain calm, have patience, give charities, maintain personal hygiene, show kindness for society(social).* (c) *Personality:- Ego-less, having ideal thoughts, having full faith in God, as religious spiritual academician, has control over oneself and is tactful in dealings, sleeps and gets up at right time, gives respect to God, cow, knowledgeable persons, teachers and elders and leads life according to seasonal environments.* (d) *Diet:- Wholesome consisting of vegetables- fruits/cereals, and milk and ghee (Dwitya Achar Rasayen)*¹⁹.

On taking wisely selected food with self-control, man lives for thirty-six thousand nights(100 years in Charak Samhita). O Lord! By your Divine Grace, all knowledgeable persons after practicing full control over their sensuous desires (Indries) during brahamcharya, grahasata, vanprahasta and sanyasa Ashrams have lived a lifespan of three hundred years. So I may also be blessed with 300 years full of physical, spiritual and social bliss.

Younger generation has been shouldered with the responsibilities of looking after elders in the family. At the time of Yagyue-Paveet (Hindu baptism ceremony), performed at the time of admission into school, the

19. Charak Samhita, Mantra No. 30 - 35.

priest recites the following mantra:- *Yague-paveet is not a simple piece of necklace consisting of three strings of simple thread, that you are going to put around your neck throughout your life. On the other hand it is a life-long reminder for your duty regarding the three debts that you have incurred, that must be repaid in this life viz. (a) Diet to God, who brought you in this world that is full of bounties for you to enjoy. This can be repaid through service to community. (b) Debt to your parents, who gave birth to you, nursed and nurtured you during difficult time to help you grow, not caring for own discomfort and enabled you to attain education and skills to be independent. This can be repaid by respectfully serving them in times of need, especially in old age. (c) Debts to Gurus (Teachers) who through imparting knowledge, made you wise. This can be repaid by dissemination of Guru's message and serving him, thus helping him in the completion of his mission.* Repayment of these debts is obligatory for the child for becoming a 'twice born' individual.

Even at the time of entry in Grahasat Ashram(ready to lead an independent family life) Manu advices as under: *Every Grahasti (family life) is supposed to perform the following five rituals daily:- (a) Brahman Yagna meaning daily prayers. (b) Dev Yagna or Homeyagna meaning offering of sacrifice to fire along with recitation of Mantras. (c) Pitri Yagna meaning obeisance to parents and receiving blessings from them. Help them if in need or during sickness. (d) Buthh Yagna meaning service to the sick or infirm members of the community or one's family. (e) Nitri or Atithy Yagna meaning provision of hospitality to guests especially scholar's etc²⁰.* Even at the time of marriage, the priest advises the newly married couple as follows:- *The son should follow his own father, by fulfilling his duties to the society, have accord with his mother through fulfilling her wishes. They should always have sweet tongue so that he can strive and work in peace²¹.*

20. Manu, Manu - Smrit ; Chapter-4.

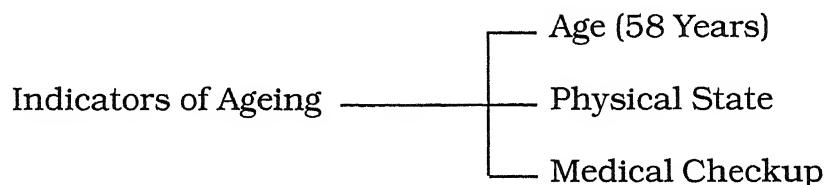
21. Atharva Veda 5/50/1

Historical evidence shows that some societies, before coming into contact with religious teachings and humanitarian values, were practising physical elimination of the crippled as they were not thought fit to survive as members of human society. The attitude of society towards the disabled has passed through different phases. Ancient society virtually denied the disabled the right to exist. But today it is no longer the case. The philosophy of modern rehabilitation services aims at the complete integration of the handicapped or disabled individual into the community or society.

India has been a pioneer in the field of rehabilitation. In the Mahabharata one would observe that kings were expected to take care of the war disabled and their dependents. Application of poultices of herbs and leaves of the neem tree and knowledge of the effects of the warmth of sunshine and invigorating influence of water and baths, all point to the high antiquity of the physical medicine in India in the third millennium B.C. The Aswins had treated paralysis and even replaced the lost leg of a soldier by an iron one. The Atharva Veda also speaks of prosthetic limbs and artificial eyes. During the Maurya period, especially the reign of Chandra Gupta, workshops were set up for vocational rehabilitation of the physically handicapped as well as other handicapped members of society. Kautilya made it a special point to employ dwarfs, the hunchbacked and other deformed people in the royal palaces. During the reign of Ashoka, charitable institutions for the care of the handicapped were established. King Harsha had also employed deformed persons in the royal palace. The Muslim rulers and the Rajput also followed the examples of the illustrious predecessors. Western invasion and other factors led to the gradual decline of these institutions and practices. The problem remained unattained until the Second World War although the efforts of philanthropic agencies continued to develop this service. In this regard the efforts of Mrs. Fatima Ismail, Mrs. Kamala Nimbkar and others are worth mentioning. In fact it is due to the efforts of voluntary and philanthropic agencies that the rehabilitation services in India gained some ground.

It would be evident from the above that the philosophy and practice of physical medicine and rehabilitation has been in existence in this country for centuries. A number of early centres attempted to operate with or without any medical direction. Today we have professional psychiatrists and other specialists to attend to them. The motto of every psychiatrist is "that every life which is saved must be made into a life worth living with dignity". During the last two decades, things have moved fast in the direction of rehabilitation services for the handicapped persons. The government is giving due consideration to develop this service²².

AGEING DETERMINENTS



Ageing is normally assumed the relation to age after 50 years but according to some learned people ageing is normally based on the factors such as age, physical state and medical checkup. Some of the important factors which plays an important role in prescribing ageing.

(i) Age : From birth till death, scientist have divided it into many stages in which old age is the last stage, which is supposed to be the mid of 50 to 60 years and person more than 60 years are also lies in this stage till their death.

(ii) Physical State : As the age progress, change in physical state is inevitable. Hair becomes white, loosing of skin, wrinkles, falling of teeths, social experience increases, becomes tired after walking short distance. At last aged are physically weak, these are the factors from which ageing can be defined.

(iii) Medical Check Up : Person becomes weak in old age in both physical and mental state; many diseases makes victim. In relation to medical check-up it has been found that more over the diseases such as

22. Rao K. S., Samiullah S., Koteswaraiah, Basha Azmal, *The Psycho-Sociological Problems of the Disabled Rural Aged, AGING, Indian Perspective & Global Scenario*, edited by Dr. Vinod Kumar, AIIMS, New Delhi, 1996, page - 130.

Blood Pressure, Pain in bones and joints, Rehumatism, Paralysis, Heart attack and Diabites, person is fall victim and seeing these in a person is said to be aged. In this old age a person suffers from different types of mental illness, due to which lack of excitement, depression, laziness, irritation, loneliness are seen in a person. By seeing these factors in a person it can be said that person is living in old age.

OTHER IMPORTANT INDICATOR OF OLD AGE :

In old age (50 years) person becomes weak, self centered, sensitive, pessimistic, sad and worried for the future life; due to which they are unable to work according to their capacity. There are some other factors which affect the person in keeping his life maintained and balanced such as they are also worried for their movable and immovable property. In addition they are also afraid for the family after them.

AGEING DEMOGRAPHY

The elderly population of India rose from 20 million in 1950, i.e. 5.5% of general population, to 55 million in 1991, i.e. 6.5% of general population, and is projected to be around 76 million by 2001 i.e. 7.7% of general population (Sharma, 1994)²³. Thus as per United Nations classification, the Indian society would progress from a 'mature-society' (i.e. elderly population between 4.7% of the total population) by the turn of century. By then, the world is projected to inhabit 612 million elderly, which would be 9.8% of world's population. In other words, one out of every seven elderly person would be from India by the year 2001.

The elderly are a fast growing population segment in India, projected to grow at (37.3%) more than double the growth rate of general population (16.8%). On disaggregating the elderly into 'young-old' (i.e. 60 to 74 years) and 'old-old' (i.e. 75 years plus) the 'young-old' were growing at rate of 4.7% and 5.3% in 1961 and 1981 respectively and are projected to grow at 5.6% by 2001. The corresponding figures for 'old-old' are 1% and 1.2% respectively (Biswas, 1994)²⁴. Thus, young-old have been

23. Sharma S.D.; Planning health care facilities for elderly. In community Geriatrics : Care of the Elderly - Issues, Status, Solutions. In Bhatta PC. (Ed.) National Institute of Primary Health Care, New Delhi, P.P. 52-55, 1994.

24. Biswas S. K. - Implications of population and ageing. In Ramchandran CR & Shah B. (Eds.), Public Health Implications of Ageing in India. Indian Council of Medical Research, New Delhi, P.P. 21-35, 1994.

increasing at a much faster pace than old-old in India, whereas globally maximal growth is recorded in the later and not in the former category of elderly (*Kinsella, 1994*)²⁵.

The world's population between 1980 to 2000 is projected to grow by 38% while the 60 plus population is expected to grow by 57%. The corresponding figures for Indian are 40% and 94% respectively. Least growth during the same period is projected to be recorded in United Kingdom, where general population would grow by only 1% while 60 plus by 1%, while in Japan, another developed country, the corresponding figures are 11% and 78.4%. On the other hand, in a developing country, like Nigeria, the corresponding growth rate would be 95% and 106% respectively (*Kurup, 1993*)²⁶. Thus the high growth rate in elderly segment of population seen in India is typical of countries where demographic transition began late.

A common and useful but crude non-economical way of analyzing impact of age structure on economic well-being is through the demographic 'dependency ratio' or 'support'. Three such ratios are generally employed which express the proportion of non-working population, viz. children (0-14) and elderly (60 plus), to working population, viz. adults (15-59). Mirroring age structure of population, elderly dependency ratio has steadily risen from 9.8 in 1951 to 11.3 in 1991, while child dependency ratio and total dependency ratio rose till 1971 and, thereafter, have fallen due to marked decline in fertility rates. Another indicator called 'index of ageing' expresses ratio of elderly (60 plus) to children (0-14) in the population. It is a useful measure of ageing process because it both defines the structure of dependent population and is very sensitive to change in that age structure. It has been steadily rising from 14.3 elderly to 100 children in 1951 to 18.4 elderly for every 100 children in 1991.

The survival or life expectancy, at birth, increased from 22.5 years in

25. Kinsella K. G. - An Aging world population. World Health 1994, 47:4:6

26. Kurup A.M. - The Challenges of ageing in India. In proceedings of the National Seminar on Ageing Scenario In India By 2001 AD, Age Care India, New Delhi, 1993, PP 17-25.

males and 23.3 years in females in 1901 to 32.4 years in males and 31.7 years in females in 1951 and became 60.1 years in males and 59.8 years in females in 1991. This increased survival coupled with high growth of general population is largely responsible for rather sudden ballooning of the elderly segment. In comparison, the average life expectancy, at birth, in developed countries was 65.7 years in 1950 and became 74.5 years in 1990 (*United Nations, 1991*)²⁷. Thus, it is evident that wide gap in life expectancy, at birth, in India from developed nations is narrowing down rapidly and it has been attributed to rapidly falling mortality rates in India and other developing countries, while they have already bottomed out in the developed countries (*Sharma, 1993b*)²⁸.

Life expectancy at age of 65 years was 7.3 years for males and 7.6 years for females in 1901. It rose to 9.8 years and 10.3 years for males and females in 1951 and by 1991, the corresponding figures were 14.6 and 16.9 years for males and females respectively (*Biswas, 1994*)²⁹. In comparison, the life expectancy at age of 65 in 1990 in USA was 15.0 years and 19.4 years for males and females respectively (*Jarvik & Small, 1995*)³⁰. Thus, life expectancy at the age of 65 years in India and developed world are gradually getting closer. It is also evident that major increment in life expectancy has occurred in later half of century, that is, in post independence era. However, increment in life expectancy at birth has been much more at birth than at the age of 60 or 65 years. This difference is primarily due to marked reduction in early age mortality because of elimination of epidemics and control of infections and parasitic diseases and not due to reduction in mortality caused by non-communicable diseases, which constitute the bulk reason of deaths in the elderly.

India is one of the few countries where sex ratio continues to be reverse, with males outnumbering females. This pattern persists in elderly

27. United Nation. World Population Prospects, 1988. United Nations, New Delhi, 1991.

28. Sharma S. P. Ageing in India. Some facts brought out by census data. In Ramacharan CR. & Shah B. (Eds). Public Health Implications of Ageing in India. Indian Council of Medical Research, New Delhi, P.P. 36-52, 1993 B.

29. Biswas - as above.

30. Jarvik LF. and Small G.W. Geriatric psychiatry Introduction and overview. In Kaplan H.I. & Sodack B.I. (Eds). Comprehensive Text book of psychiatry, VI Edition. Williams & Wilkins, Baltimore, P 2507, 1995.

segment and females outnumber males only beyond the age of 70 or 75 years (Biswas, 1994)³¹. On the whole, the number gap between males and females has widened by as much as ten times, whereas general population has grown only by factor of four between 1901-1991.

Surprisingly, the number of elderly females was much more than elderly males in 1901, but due to growth of elderly males outpacing that of elderly females became equal in number by 1961 and today elderly males outnumber elderly females (Sharma, 1994)³². The reason for pervasive sexual discrimination has primarily to be sought in the socio-cultural milieu of society.

The magnitude of the problem can only be visualized from the fact that the percentage of elderly is fast rising. As per 1981 census, there were 4.32 crore people in India who were 60 years and above in age. As per current estimates, the population of elderly may be as much as 7.5 crores by the turn of the century. Similarly, elderly population in the world over is on the rise. It is figured that in 2025, every seventh person i.e. 14 percent of the population or 1.2 billion people worldwide, will be older than 60 years. In 1950, the corresponding proportion was only 8 percent. The population aged 80 or above will increase from 13 to 137 million in 2025.

The growth factor of the overall population will be 3, for the 60 plus group it will be 6, and for the 80-plus it will be as high as 10.

The elderly population of the world is estimated to increase from 256 million to 658 million by the year 2000 as a consequence of 25% increase in life span. The developing countries will account for most of the projected increase. The total population above 60 years in India was 58 million in 1991 which is likely to cross 76 million in 2025. The health planners now face the challenges of coping with increased aged population in future. In the Indian context, the eighth five year plan (1992-97) has aimed at providing schemes of old age pensions under the state government for elderly persons without any means of support.

31. Biswas - as above.

32. Sharma, 1994 - as above.

AGED IN JOINT FAMILY SYSTEM

In ancient period varna shram system was basis of Hindu Social Organization. The total development of individual personality was possible through Ashram System.

Vanprastha ashram, was important stage of old age. According to Manu, when individual observed that his body skin began to loose, hair of head began to white, grand son and daughter borned than he should go to forest by dedication of attachment of house. Vanprastha was called gurukul in forest where some varna's children used to go for studying. All expenditure of Gurukul was bared by grahasth ashram. After the end of gurukul system the responsibility of aged was of the joint family system, which was supposed to be better place for the aged. Till now where there is joint family system in rural areas, aged are being provided support and security, Respect for the aged is a basic characteristic of this system. "Honour thy father and they mother" expresses the veneration of the elders in our scriptures and literature. The system of ancestor worship that dominated Indian social life for centuries and even now, continues to dominate and gives Indians a philosophy to care and honour their old parents.

In traditional social system, the old aged persons were endowed with power, authority and respect. They were revered because of the reservoir of their wisdom and execution of their duties to their children and grand children. The old aged persons, even after disengagement from active life, were looked after by the younger generation. The old aged persons received the highest respect at the stage of Vanaprastha and served the society by imparting religious education. They were considered as wisdom personified. Traditional Indian value system emphasized on reverence for age, premium on wisdom and experience of the elderly, strong family support system and contentment in old age.

For the aged persons, the traditional family norms and values were a great source of care. Joint family met the social, economic and emotional needs of its members. In times of illness, distress, destitution

and deaths; joint family served the role of social security and insurance. To the old aged persons, joint family provided not only economic support but emotional and human warmth too. In joint family, the old aged persons never felt unwanted. They got love and care and were almost deified. But in present scenario, joint family system has split in nuclear family system and the family members leaving their elderly emotionally and spiritually miserable and mentally demented. Such parents have experienced disorientation and depression due to the fact of seeing their life long labour of love in shambles. They suffer from a sense of social capitulation, remorse, loss of self esteem and worthlessness. They are thus virtually the 'living dead'. There are many factors due to which joint family split and aged are feeling helpless and unsecure; these are; industrialization, western education, urbanization changing social and economic capability, technology, upward mobility, material prosperity, changing gender and generational relationship, growing demand on the family to prepare its members for a competitive world, increasing longevity, the resources of the family for care in different locations, the nature of care burden, cost of care, re-allocation of time and roles, nucleation of families etc.

The changing values of society are effecting our traditional system as well as the culture. Today modernization has also effected the aged and produced the problem of isolation.

STATUS OF AGED

The Status of the age in India in the past was not much different from what it was in other earlier cultures. The old were generally respected. The average expectation of life was short, the death rate was high and the proportion of the old in the total population was very small. The centenarian or the octogenarian was in fact a wonder. The old were never a burden to the family. An old man continued to work in the farm or home till late in his life. The

old women nursed their grand children and provided native medicine to the sick in the family. The grandfather, if he were literate, taught

the Fil(iren to read and write. If the old were fit for nothing else, they could at least provide watch and ward for the family and look after the very young. The carpenters, potters, weavers, blacksmiths and other village artisan classes did not retire from active work even when they were old. Infact their services were highly valued as they advanced in age and experience. They continued to contribute their mite to the family income. Hence it was natural that the old were accorded a high status.

There were other reasons also. The wisdom and experience (of the old was an asset to the community. It compensated the lack of literacy, training and the devices of storing and retrieving of knowledge. The young learnt their trade and skill by imitating the old and the experienced. The budding musicians, actors, sculptors, priests, scholars and artists were trained in this manner. Naturally, therefore, age received its due recognition and honour. The ancient families and communities possessed no written documents or clearly laid out judicial procedures to enlighten them on matters of importance. The wisdom of the old was the only resource. It was not surprising, therefore, that the village councillors (sarpanchas) were invariably the old people who headed important families and caste groups.

PROBLEMS OF AGEING

Old age, in general, is a multi dimensional problem. The problems which are associated with old age and the care of elderly are not exclusively the problems of social, cultural, economic, psychological ramifications rather they include health and medical problems also that affect the life of community as well *Swaminathan D. (1996:20)* wrote about multy - dimensional problems of ageing that ageing is equal to a specific disease. It is that disease by which each individual is infected, that man who lives, other diseases also captured the ageing. Several problems - family and community adjustment, loneliness, seperation, non-utilisation of leisure time and meagre income to support himself and dependents along with physical and mental weakness³³.

Psychological or emotional problems and social problems are the

33. Swaminathan D.; Integration of the aged into the development process in India, Vol. - 2, No. - 2, 1996, Indian Journal of Research and Development, New Delhi, page - 20.

derivatives of familial problems. The familial problems are mainly concerned with neglect and poor up-keep and in its wake give rise to emotional and psychological problems associated with sickness. The feeling of dependency on other during sickness causes emotional disturbance, besides adverse emotional reaction while ill. Another type of emotional disturbance is rooted in loneliness and physical isolation mostly among those have outlived their relations, or are estranged from them and live alone.

Health and medical care is a major problem for the aged. Even when one is not suffering from any disease, one experiences a gradual decline in physical strength with growing age. But in most cases the advanced age brings with it some chronic ailment and the aged get bed ridden and depend on others for thier mobility and need medical care for their treatment.

The housing conditions of most of the aged are generally far from satisfaction. The problem is particularly acute among those who live alone. They are obliged to share accomodation with others. As a matter of fact, this problem is also associated with the economic problem. As well as the majority of the elderly people have financial problems. Even those who are the recipients of retirment benefits after superannuation find it difficult to meet their basic requirements with decrease in their income and increase in the cost of living. In many countries of the West it is noticed that leisure in the sunset years could be pathogenic. For the 'Workholics' or those to whom work has been central in their life, super abundance of leisure is a curse rather than a blessing. It is specially true in the cases of those who are compelled to abstain from work, whose auditory and visual senses are impaired, whose insolation is increased with decreasing frequency of visits to and from relatives and friends, who feel lonely after the death of their partners and who have to battle not only against social neglect but also economic deprivation. Providing subsitute leisure time activites to the aged so that they may not feel lonely and unhappy, is a very difficult problem India is now beginning to face this problems.

There are physical effects of ageing. However, old age as such cannot be identified with ill health or disability, although advancing age tends to bring increased health problems. Hearing loss, blindness, lower immunities to illness, loss of memory power, hardening of blood vessels, respiratory and digestive disorders, heart ailments, arthritis etc. are usually associated with old age. These could be taken care of satisfactorily by those who have adequate financial and familial support. For large majority of the aged in India support, especially the institutional support, is totally lacking.

MYTHS RELATED TO ELDERLY

MOST OLDER PEOPLE LIVE IN DEVELOPED COUNTRIES :

In fact the reverse is true. Most older people, over 60% of them, live in developing countries. There are currently about 580 million older people in the world, with 355 million in developing countries. By 2020, there will be 1,000 million, with over 700 million in the developing world. The reason for this is the sharp decline in premature mortality, from many infectious and chronic diseases during this century. Improvements in sanitation, housing, nutrition and medical innovations, including vaccinations and the discovery of antibiotics have also contributed to the steep increase in the number of people reaching older age.

Sharp increase in life -expectancy have been accompanied by substantial falls in fertility all over the world, mainly due to modern contraceptive methods. In India, for example, total fertility rates (that is, the total number of children a woman is expected to have) have decreased from, 5.9 in 1970 to 3.1 in 1998. In Brazil fertility rates dropped from 5.1 in 1970 to 2.2 in 1988. This decline is even more pronounced in China, where the 'one child-per-family' policy was officially introduced in 1979. Total fertility rates fell from 5.5 in 1970 to the current 1.8 which is below the 2.1 replacement level.

This trend by which more people live to reach older age while fewer children are born is referred to as 'population ageing'. It has been

particularly rapid in developing countries. While it has taken France 115 years for the proportion of older people to double from 7 to 14%, it will take China only 27 years to achieve the same increase, between 2000 and 2027.

OLDER PEOPLE ARE ALL THE SAME :

'Older people' constitute a very diverse group. Many older people lead active and healthy lives, while some much younger 'older people' have a poorer quality of life. People age in unique ways, depending on a large variety of factors, including their gender, ethnic and cultural backgrounds, and whether they live in industrialised or developing countries, in urban or rural settings. Climate, geographical location, family size, like skills and experience are all factors that make people less and less alike as they advance in age.

Individual variations in biological characteristics (e.g. blood pressure or physical strength) tend to be greater between older people than between young ones: the characteristics of two ten-years-old would be more similar than those of two eighty-year-olds. Such diversity leads to considerable difficulties in interpreting results from scientific studies on ageing, which are often conducted on particular, well defined groups of older people: the findings may not apply to a large proportion, or even the majority of older people.

The differences are further increased by disease experiences throughout life which may accelerate the ageing process. Many studies have shown that there are wide variations in patterns of disease in people from different ethnic and cultural communities which remain largely unexplained. For example, immigrants and their descendants who move from the Indian subcontinent to countries across the globe have higher rates of coronary heart disease than the population of the countries to which they moved.

MEN AND WOMEN AGE THE SAME WAY :

Women and men age differently. First of all, women live longer than men. Part of women's advantage with respect to life expectancy is

biological. Far from being the weaker sex they seem to be more resilient than men at all ages, but particularly during early infancy. In adult life too women may have a biological advantage, at least until menopause, as hormones protect them from ischaemic heart disease, for example. Currently, female life expectancy at birth ranges from just over 50 years in the least developed countries to well over 80 in many developed countries, where the typical female advantage in life expectancy ranges from five to eight years. As a result, the oldest old in most parts of the world are predominantly women. However, longer lives do not necessarily translate into healthier lives and patterns of health and illness in women and men show marked differences. Women's longevity, makes them more likely to suffer from the chronic diseases commonly associated with old age. We know, for instance, that women are more likely to suffer from osteoporosis, diabetes, hypertension, incontinence, and arthritis than men. By reducing mobility, chronic disabling diseases such as arthritis have an impact on the capacity to maintain social contracts and thus on the quality of life. Men are more likely to suffer from heart disease and stroke, but as women too. The common view that heart disease and stroke are exclusively men's problems has obscure recognition of their significance for older women's health and more research is necessary in this area.

OLDER PEOPLE ARE FRAIL :

Far from being frail, the vast majority of older people remain physically fit well into later life. As well as being able to carry out the tasks of daily living, they continue to play an active part in community life. In other words, they maintain high 'function capacity'. As in all aspects of ageing, there are differences in the way functional capacity is maintained in different groups of older people. Although women live longer than men, they tend to experience more disabling diseases as they grow older compared with men of the same age. There is also a wide variation in the perceived need for certain functional abilities among older people. In some societies, for example, fetching water and firewood are tasks traditionally, carried out by women. Maintaining maximum

functional capacity is as important for older people as freedom from disease.

OLDER PEOPLE HAVE NOTHING TO CONTRIBUTE :

The truth is that older people make innumerable contributions to their families, societies and economies. The conventional view that perpetuates this myth tends to focus on participation in the labour force and its decline with increasing age. It is widely assumed that the fall in numbers of older people in paid work is due to decline in functional capacity associated with ageing. In fact, declining functional capacity does not by any means equate to inability to work. Indeed, the physical requirements of many jobs have been reduced by technological advances, permitting severely disabled people to be fully economically productive. In addition, the fact that there are fewer older people in paid work is more often due to disadvantages in education, training and particularly to 'ageism', than to older age per se.

The widely held belief that older people have nothing to contribute also relies on the notion that only paid occupations count. However, substantial contributions are made by older people in unpaid work including agriculture, the informal sector and in voluntary roles. Many economies worldwide depend to a large extent on these activities, but few of them are included in the assessment of national economic activities, leaving the contribution made by older citizens often unnoticed and undervalued.

OLDER PEOPLE ARE AN ECONOMIC BURDEN ON SOCIETY :

Older people contribute in innumerable ways to the economic development of their societies. However, two concurrent developments have contributed to the myth that societies will not be able to afford to provide economic support and health care for older people in the years to come. One of these developments is the growing realisation of the sheer numbers of citizens who will be living to older ages in the next century. The second development is the greater emphasis on market forces in almost all parts of the world, and the related debate about the

proper role of the state in providing income security and health care for its citizens.

There has been growing concern in many, particularly industrialised, countries about the levels of state expenditures, for social protection and whether costs could be reduced by opening social protection to more private sector competition. This worldwide debate has unfortunately placed the entire emphasis on the cost to society of providing pensions and health care for older people rather than on the continuing and significant economic contributions that older citizens make to society. It has given rise to the widely held myth that older citizens make to society. It has given rise to the widely held myth that older persons are generally economically dependent and thus a burden on society. The facts, however, demonstrate that this is not a true reflection of reality. Two important considerations-work and public pension protection-must be taken into account³⁴.

In the present time things have changed from bad to worse in the recent parts as far as the aged are concerned. However, It is beyond doubt that the aged in India now have a feeling of being neglected, if not being let down or despised. A rection of the young complain of the competition from the old. Some consider them as a drag. Some have stopped taking care of the old. Some at least are less indulgent or less respectful. Very often they migrate to cities, with or without their spouses, in search of employment or freedom, leaving the old men and women in their ancestral homes with increased improtance given to money income, the old people who can not earn as much as the young, are naturally disadvantaged. The urban homes find it difficult to accommodate the old men and women. The working sons or daughters in law find in difficult to take care of the old parents in law. The old people have started grumbling about, if not protesting against, their lot. As in other parts of the world, the old people in India are experiencing a deterioration in their status.

So far as the perception of aged about their family members. Elderly persons are oftenenly tells that our family members understand us as

34. A WHO Document published in HCPT / NIPHC, Lecture Series in Geriatrics, New Delhi, Feb. 2000.

buden and they are neglected by their family.

NUTRITION OF OLDS

Food is a basic human necessity we all need to eat to live. But in nearly every society it plays a much bigger role than this physical one. It is the focus of much daily activity (obtaining, cooking, as well as eating it), and it forms the basis of many social gatherings (family meals, celebrations and festivals). Our need for it, both physically and socially, continues unchanged in old age but certain factors lead to difficulties unless they are effectively dealt with. Nutritional needs in later life and at age related and social changes which may affect the older person's ability to meet these needs have to be understood.

The requirement of specific nutrients for elderly individuals falls into one or two categories, according to whether or not the amount of the nutrient is a function is a function of energy intake. Some nutrients are required in amounts which vary directly with the total energy intake, others are independent of energy intake. There are some nutrient which are useful and necessary for elderly; Protein needs reflect body size and composition and are almost related to total energy output. As a result of poor digestive capacity and decreased appetite, the elderly are like to consume less proteins leading to protein deficiency. ICMR recommended allowances of protein is 60 gms and 50 gms / day for male and female elderly respectively (1995).

Munro (1972), on the basis of few nitrogen balance studies carried out on the elderly, has calclated that protein requirments are about 0.6 gm/kg/day, which corresponds to an intake of 40 gm of portein or less / day.

Studies carried out by Cheng et al (1978) and by Zanni et al (1979) show protein requirements to be similar to adult recommendation. The recommended allowance is one gram / Kg body weight (Swaminathan, 1990). One gram of Protein in food provides four kilo calories and sources of protein rich foods are meat, fish, chicken, organ meat, egg, pulses, milk, mushroom, oil seeds and nuts. There is no reason to prefer animal

protein over plant protein if adequate quantity of cereal and pulses are combined and supplemented with recommended amounts of dairy products. Non vegetarians are encouraged to consume fish and poultry.

Fat adds palatability as well as satiety to food. It is recommended that less than 30% of the total calories should be from fat. This works out to be 40-45 gm of total visible and invisible fat, therefore, cooking fat should not be more than 15-20 mg per day.

Minerals, the minerals, calcium and iron are required in quantities which are related to body size and not to energy expenditure.

Vitamins are involved in the utilization of the major nutrients like proteins, fat and carbohydrates. The vitamins which are likely to be present in inadequate amounts in the diets of elderly people are some of the B group, Vitamin C and Vitamin D.

Vitamin A is necessary for clear vision in dim light and Vitamin (deficiency causes scurvy characterized by weakness and spongy bleeding gums. The ICMR, RDA of vitamin A and Vitamin C is 2400 mg/day and 40 mg/day respectively.

Seasonal fruits like mangoes, papaya, tomatoes, greens and all yellow vegetables are good sources of Vitamin A. Also fish liver oil preparations from shark and sea fish are being used extensively as vitamin A supplement, fruits like grapes, orange, tomato, gooseberry and fresh vegetable especially greens contain good amount of vitamin C. Hence it is advisable for elders to consume any of the fruits daily.

The deficiency of B complex vitamin thiamine leads to the disease beri-beri and riboflavin inadequacy leads to soreness of tongue, fissures at the angle of mouth and haziness of cornea with defective vision. The rich sources of the thiamine is yeast and the outer layers of cereals like rice, wheat and millets. Also pulses and nuts, particularly ground nut contain high level of thiamine, inclusion of milk and milk products, eggs, liver, pulses and greens will improve the dietary supply of riboflavin.

Lack of niacin in the diet leads to defective mental faculty (dementia),

skin disorder (dermatitis) and diarrhoea. Whole cereals, pulses, meat and nuts especially ground nuts are rich sources of this vitamin³⁵.

GOVERNMENT EFFORTS

Of late Aging has become a concern in our country. Rapid demographic changes in longevity and resultant dependence and destitution of the aged, have drawn the attention of the government at all levels. The State is committed under Article 41 to provide public assistance in cases of old age, disablement and other cases of undeserved want. Article 246 of VIIth Schedule, List-II provides relief to the disabled and unemployable. Under List-III, against item 23, Social Security and Social Insurance is the responsibility of the State.

It is in this context of the constitutional obligations that certain programmes have been specifically worked out by the States and Central Government directly as well as in cooperation with NGOs. Majority or share of the programmes is concentrated for the senior citizens under the unorganised sector of economy which constitutes about 80% of the total elderly population of the country. Senior citizens under organised sector of economy are entitled to various social security, social insurance and economic assistance programmes after superannuation. It is unorganised sector where the need is far more. For this sector, programmes like old age pension, old age homes, day care centres, mobile medicare services, adoption of elderly, socio-economic activities for supplementary income etc. are some of the illustrative typical programmes being undertaken all over the country. On an average 12-15% elderly destitutes are covered under these programmes, leaving much to be desired. A beginning has already been made in this direction Planning Commission, Tenth Finance Commission, Ministry of Welfare and State Governments are increasingly providing funds for various welfare and developmental programmes, for the elderly. An Inter-ministerial Group has been constituted by the Ministry of Welfare to work out a National Policy for the Elderly, which itself is an indicator of our concern for them.

Like other welfare activities for vulnerable groups, this sector also

35. Khosla Ishi, Nutrition in the Elderly - the basic, HCPT / NIPHC, Lecture Series in Geriatrics, edited by Dr. P.C. Bhatla, New Delhi, 2000.

requires collaborative efforts of the Government, voluntary sector and international bodies to meet the need which far exceeds the services provided so far. Our case is no different than the case of other developing countries in the region. Deliberations like this can provide valuable material for policy formulation and programme planning for the Government at different levels³⁶.

Old persons in affluent countries are mostly assured of a fairly decent living owing to the comprehensive social security measures which are available. Compared to what has been done in for the aged in the western countries, the efforts made in India are not even a drop in the ocean. Much of the care of the is confined to three types of programmes namely, retirement benefits, homes for the aged people and old age pension schemes. Those who retire from service from organised sectors are given retirement benefits by employers (both government and non-government) by way of pensions, provident fund, gratuity, etc. However, the employees in the organised sectors constitute only a small portion of the working force in India.

Retirement benefits, old age pensions and homes for the aged are worthwhile; but not adequate steps in the direction of providing security to the aged it is hard reality that the governemt and people in india have not realised the seriousness of the problem and the necessity of a clearly spelt out policy for the aged. This is mainly attributed to financial constraints. There is no legislation requiring payment of pension or financial asisstance to the aged. The Central Government have no programme of old age pension to the general population nor do they give grant to the State Government for the purpose.

The only other note worthy scheme undertaken for the welfare of the aged related to the institutional services of homes for the aged, organised by state government or by the voluntary organisations. Homes for the aged run by State Governments do not require any contribution from the inmates owing to the pre-condition of having no income. Generally they are reported to be poorly run. For certain categories of

36. Khan I.H. Ministry of Welfare, Government of India written in AGING, Indain Perspective and Global Scenario, edited by Dr. Vinod Kumar, AIIMS, New Delhi, 1996.

old destitutes it is inevitable to have such homes for want of care from relations or total obsense of near relations.

The Ministry of Social Justice and Empowerment has been implementing a central scheme of assitance for establishing and maintaining the day care centres, old age homes, mobile medicare units as well as supporting and strengthening non-institutional service for the aged. This revised scheme is called as 'An integrated programme for Older Persons.

This is not to deny that the Government of India made some efforts for the aged but after that there are some challenges before us related to the aged. The biggest challenge is lack of political will in many countries resulting in allocation of meagre resources for the neglected areas of social welfare such as care of the elderly, there are serveral more challenges and these include the need for radical change in the perceptions about the potential strengths current contributions of the older peoples to the society. Another challenge arises out of separate and selective advocacies of the situation of different segment of the vulnerable populations. This has resulted in their being distanced and disassociated from broader policy frame work and even contributing to competition for public attention and limited resources. Yet, another challenge relates to organizations of older persons as well as those working on their behafl. Private organizations and organizations of older persons should not only place high priority on areas and activites relevant to older persons.

The elderly have a rightful to play on all these fronts. Another set of challenges concern the elderly themselves in their life choice, their willingness to take risk and make sacrifices, and their readiness to redefine the goals of their life. the elderly also have to face many dilemma relating to choices of occupation, residence, relations with other family members, changing long-held beliefs and behaviourl patterns, adopting a positive stance to social change and adapting to it. The elderly in any society are not a heterogenceous group. Some of them are affluent, better educated and better situated. Finally, the biggest challenge is the ned to bring about change of the perceptions that the old have about themselves.

BUDGET ALLOCATION FOR AGED

U.P. BUDGET FOR AGED - 2004-05 :

(In thousand)

1. National Old Age Pension Scheme -	648000
2. Old Age Homes	2394

CENTRAL BUDGET FOR AGED :

❖ 3 crore allocated to old age homes

❖ Ministry of Finance, Govt. of India, introduced fund for Aged under National Social Assistance programme :-

◆ 835 crore rupees provided for National Social Assistance Scheme for giving pension to 62 lakh destitute under National Old Age Pension Scheme; and compensating 2.40 lakh households of the deceased under the National Family Benefit Scheme.

◆ 300 crore rupees provided for the scheme "Annapurna" which aims at providing food security @ 10 Kgs. of food grains per month to all those who, though eligible for old age pension remain uncovered under National Old Age Pension Scheme. About 40 lakh beneficiaries will be eligible under this scheme.

◆ Financial assistance in the form of old age pension given to 1.14 lakh senior citizens with effect from 1st January, 2002 the pension amount was increased from Rs. 200 to Rs. 300, now from next year the number of beneficiaries would be increased from 1.14 lakh to 1.25 lakh.

◆ To provide DTC passes at concessional rates to senior citizens in the age group of 65 years and above. All route DTC passes will be provided to them for Rs. 50 only.

◆ Construction of integrated complexes for senior citizens with facilities like library, dispensary, recreation centres besides residential facilities will be started in West Delhi, an outlay of Rs. 2 crore is proposed in 2003-2004.

- ◆ Delay in allotment of land by DDA proved a stumbling block for construction of Old Age Homes. Land obtained at Rohini and Dwarka for two new Old Age Homes.
- ◆ 5 Crore allocated to old age homes.
- ◆ LIC to launch a pension scheme called Jeevan Suraksha.

NATIONAL POLICY ON OLDER PERSONS (1999)

THE BACKGROUND

DEMOGRAPHIC TRENDS

1. Demographic ageing, a global phenomenon, has hit Indian shores as well. People are living longer. Expectation of life at birth for males has shown a steady rise from 42 years in 1951-60 to 58 years in 1986-90; it is projected to be 67 years in 2011-16, an increase of about 9 years in a twenty five year period (1986-90 to 2011-16). In the case of females, the increase in expectation of has been higher about 11 years during the same period, from 58 years in 1986-90 to 69 years in 2011 - 16. At age 60 too, the expectation of life shows a steady rise and is a little higher for Women. In 1989 -93, it was 15 years for males and 16 years for females.

2. Improved life expectancy has contributed to an increase in the number of persons 60+ From only 12 million persons 60+ in India in 1901, the number crossed 12 million in 1951 and 57 million in 1991. Population projections for 1996-2016 made by the Technical Group on the Population Projections (1996) indicate that the 100 million mark is expected to be reached in 2013. Projection beyond 2016 made by the United Nations (1996 Revision) has indicated that India will have 198 million persons 60+, in 2030 and 326 million in 2050. The percentage of persons 60+ in the total population has seen a steady rise from 5.1 per cent In 1901 to 6.8 per cent in 1991. It is expected to reach 8.9 per cent in 2016. Projections beyond 2016 made by United Nations (1996 Revision) has indicated that 21 per cent of the Indian population will be

60+ by 2050.

3. Growth rate on a larger demographic base implies a much larger increase in numbers. This will be the case in the coming years. The decade 2001-11 is expected to witness an increase of 25 million persons 60+ which is equivalent to the total population of persons 60+ in 1961. The twenty five year period 1991 to 2016 will witness an increase of 55.4 million persons 60+ which is nearly the same as the population of persons 60+ in 1991. In other words, in a twenty five year period starting 1991, the population 60+ will nearly double itself.

4. Sixty three per cent of the population in 1991 (36 million) is in the age group 60-69 years, often referred to as 'young old' or 'not so old' while 11 percent (6 million) is in the age group 80 years and over i.e. in the 'older old' or 'very old' category. In 2016, the percentage in these age groups will be almost the same, but the numbers are expected to be 69 million and 11 million respectively. In other words, close to six-tenth of the population 60-69 years can be expected to be in reasonably good physical and mental health, free of serious disability and capable of leading an active life. About one-third of the population 70-79 years can also be expected to be fit for a reasonably active life. This is indicative of the huge reserve of human resource.

5. Men outnumber women in India even after age 60 (29 million males, 27 million females 60+ in 1991). This will continue to be the situation in 2016 when there will be an estimated 57 million males and 56 million females 60+.

6. Incidence of widowhood is much higher among females 60+ than among males of the same age group because it is customary for women to get married to men older by several years; also, they do not remarry and live longer. There were in 1991, 14.8 million widowed females 60+ compared to 4.5 million widowed males. In other words, there were four times as many widowed females as widowed males.

IMPLICATIONS

7. The demographic ageing of population has implications at the micro and also at the macro and also at household level. The sheer magnitude of numbers is indicative both of the huge human reserve and also of the scale of endeavours necessary to provide social services and other benefits.

8. Demographic transition has been accompanied by changes in society and economy. These are of a positive nature in some areas and a cause of concern in others.

9. A growing number of persons 60+ in the coming decades will belong to the middle and upper income groups, be economically better off with some degree of financial security, have higher professional and educational qualifications, lead an active life in their 60s and even first half of the 70s, and have a positive frame of mind looking for opportunities for a more active, creative and satisfying life.

10. Some areas of concern in the situation of older persons will also emerge, signs of which are already evident, resulting in pressures and fissures in living arrangements of older persons. It is true that family ties in India are very strong and an overwhelming majority live with their sons or are supported by them. Also working couples find the presence of old parents emotionally bonding and of great help in managing the household and caring for children. However, due to the operation of several forces, the position of a large number of older persons has become vulnerable due to which they can not take for granted that their children will be able to look after them when they need care in old age, specially in view of the longer life span implying an extended period of dependency and higher costs to meet health and other needs.

11. Industrialisation, urbanisation, education and exposure to life styles in developed countries are bringing changes in values and life styles. Much higher costs of bringing up and educating children and pressures for gratification of their desires affects transfer of share of income for the care of parents. Due to shortage of space in dwellings in

urban areas and high rents, migrants prefer to leave their parents in their native place. Changing roles and expectations of women, their concepts of privacy and space, desire not to be encumbered by caring responsibilities of old people for long periods, career ambitions, and employment outside the home implies considerably reduced time for care giving. Also, adoption of small family norm by a growing number of people implies availability of fewer care givers specially since in a growing number of families, daughters, too, are fully occupied, pursuing their educational or work career. The position of single persons, particularly females, is more vulnerable in old age as few persons are willing to take care of non-lineal relatives. So also is the situation of widows an overwhelming majority of whom have no independent source of income, do not own assets and are totally dependent.

THE MANDATE

12. Well being of older persons has been mandated in the Constitution of India. Article 41, a Directive Principle of State Policy has directed that the state shall, within the limits of its economic capacity and development, make effective provision for securing the right to public assistance in cases of old age. There are other provisions, too, which direct the State to improve the quality of life of its citizens. Right to equality has been guaranteed by the Constitution as a Fundamental Right. These provisions apply equally to older persons. Social security has been made the concurrent responsibility of the Central and State, Governments.

13. The last two decades have witnessed considerable discussion and debate on the impact of demographic transition and of change in society and economy on the situation of older persons. The United Nations Principles for Older Persons adopted, by the United Nations General Assembly in 1991, the Proclamat on Ageing and the Global Targets on Ageing for the year 2001 adopted by the General Assembly in 1992 and various other Resolutions adopted from time to time, are intended to encourage governments to design their own polices and programmes in

this regard.

14. There has for several years been a demand for a Policy Statement by the State towards its senior citizens so that they do not face an identity crisis and know where they stand in the overall national perspective. The need has been expressed at different forums where ageing issues have been deliberated. The Statement, by indicating the principles underlying the policy, the directions, the needs that will be addressed and the relative roles of governmental and non-governmental institution, is expected to facilitate carving out of respective areas of operation and action the direction of a humane age integrated society

NATIONAL POLICY STATEMENT

15. The National Policy seeks to assure older persons that their concerns are national concerns and they will not live unprotected, ignored or marginalised. The goal of the National Policy is the well-being of older persons. It aims to strengthen their legitimate place in society and help older persons to live the last phase of their life with purpose, dignity and peace.

16. The Policy visualises that the State will extend support for financial security , health care, shelter, welfare and other needs of older persons, provide protection against abuse and exploitation of older persons, seek their participation, and provide services so that they can improve the quality of their lives. The Policy is based on some broad principles.

17. The Policy recognises the need for affirmative action in favour of the elderly. It has to be ensured that the rights of older persons are not violated and they get opportunities and equitable share in development benefits. Different sectors of development, programmes and administrative actions will reflect sensitivity to older persons living in rural areas. Special attention will be necessary, to older females so that they do not become victims of triple neglect and discrimination on account of gender,widowhood and age.

18. The Policy views the life cycle as a continuum, of which post 60 phase of life is an integral part. It does not view age 60 as the cut off for beginning a life of dependency. It considers 60+ as a phase when the individual should have the choices and the opportunities to lead an active, creative, productive and satisfying life. An important thrust is, therefore, on active and productive involvement of older persons and not just their care.

19. The Policy values an age integrated society. It will endeavour to strengthen integration between generations, facilitate have way flows and interactions, and strengthen bonds between the young and the old. It believes in the development of a social support system, informal as well as formal, so that the capacity of families to take care of older persons is strengthened and they can continue to live in their family.

20. The Policy recognises that older persons, too, are a resource. They render useful services in the family and outside. They are not just consumers of goods and services but also their producers. Opportunities and facilities need to be provided so that they can continue to contribute more effectively to the family, the community and society.

21. The Policy firmly believes in the empowerment of older persons so that they can acquire better control over their lives and participate in decision making on matters which affect them as well as on other issues as equal partners in the development process. The decision making process will seek to involve them to a much larger extent specially since they constitute 12 per cent of the electorate, a proportion which will rise in the coming -years.

22. The Policy recognises that larger budgetary allocations from the State will be needed and the rural and urban poor will be given special attention. However, it is neither feasible nor desirable for the State alone to attain the objectives of the National Policy. Individuals, families, communities and institutions of civil society have to join hands as partners.

23. The Policy emphasises the need for expansion of social and

community services for older persons' particularly women, and enhance their accessibility, and use by removing socio-cultural, economic and physical barrier and making the services client oriented and user friendly. Special efforts will be made to ensure that rural areas, where more than three-fourth of the older population lives, are adequately covered.

PRINCIPAL AREAS OF INTERVENTION AND ACTION STRATEGIES

FINANCIAL SECURITY

24. A great anxiety in old age relates to financial insecurity. When the issue is seen in the context of fact that one-third of the population (1993-94) is below the poverty line and about one-third are above it but belong to the lower income group, the financial situation of two thirds of the population 60+ can be said to fragile. Some level of income security in old age is a goal which will be given very high priority. Policy instruments to cover different income segments will be developed.

25. For elderly persons below the poverty line, old age pensions provide some succour. Coverage under the old age pension scheme for poor persons will be significantly expanded from the January 1997 level of 2.76 in million with the ultimate objective of covering all older persons below the poverty line. Simultaneously, it will be necessary to prevent delays and check abuses in the matter of selection, and disbursement. Rate of monthly pension will need to be revised at intervals so that inflation does not deflate its real purchasing power. Simultaneously, the public distribution-system will reach out to cover all persons 60+ living below the poverty line.

26. Employees of government and quasi government bodies and industrial workers desire better returns from accumulations in provident funds through prudent and safe investment of the funds. Issues involved will be given

careful consideration. It will be ensured that settlement of pension, provident fund, gratuity and other retirement benefits is made promptly

and superannuated persons are not put to hardship due to administrative lapses. Accountability for delays will be fixed. Redressal mechanisms for superannuated persons will ensure prompt, fair and humane treatment. Widows will be given special consideration in the matter of settlement of benefits accruing to them on the demise of husband.

27. Pension is a much sought after income security scheme. The base of pension coverage needs to be considerably expanded. It would be necessary to facilitate the establishment of pension schemes both in the private as well as in the public sector for self-employed and salaried persons in non-governmental employment, with provision for employers also to contribute. Paramount considerations in regard to pension schemes are total security, flexibility, liquidity and maximisation of returns. Pension Funds will function under the watchful eye of a strong regulatory authority which lays down the investment norms and provide strong safeguards.

28. Taxation policies will reflect sensitivity to the financial problems of older persons which accelerate due to very high costs of medical and nursing care, transportation and support service needed at home. Organisations of senior citizens have been demanding a much higher standard deduction for them and a standard annual rebate for medical treatment, whether domiciliary or hospital based, in cases where superannuated persons do not get medical coverage from their erstwhile employers. There are also demands that some tax relief must be given to son or daughter when old parents coreside and also allow, some tax rebate for medical expenses. These and other proposals of tax relief will be considered.

29. Long term savings instruments will be promoted to reach both rural and urban areas. It will be necessary for the contributors to feel assured that the payments at the end of the stipulated period are attractive enough to take care of the likely erosion in purchasing power due to erosion. Earners will be motivated to save in their active working years for financial security in old age.

30. Pre-retirement counselling programmes will be promoted and assisted.

31. Employment in income generating activities after supernannuation should be the choice of the individual. Organisations which provide career guidance, training and orientation, and support services will be assisted. Programmes of non-governmental organisations for generating incomes of old persons will be encouraged. Age related discrimination in the matter of entitlement to credit, marketing and other facilities will be removed. Structural adjustment policies may affect the older workers in some sectors more adversely, specially those in household or small scale industry. Measures will be taken to protect their interests.

32. The right of parents without any means, to be supported by their children having sufficient means, has been recognised by Section 125 of the Criminal Procedure Code. The Hindu Adoptions and Maintenance Act, 1956, too secures this right to parents. To simplify the procedure provide speedy relief, lay down the machinery for processing cases, and define the rights and circumstances in a comprehensive manner, the Himachal Pradesh, Legislative Assembly passed the Himachal Pradesh Maintenance of Parents and Dependents Bill, 1996. The Government of Maharashtra, has prepared a Bill on similar lines. Other States will be encouraged to pass similar legislation so that old parents unable to maintain themselves do not face abandonment and acute neglect.

HEALTH CARE AND NUTRITION

32. With advancing age, old persons have to cope with health and associated problems some of which may be chronic, of a multiple nature, require constant attention and carry the risk of disability and consequent loss of autonomy. Some health problems, specially, when accompanied by impaired functional capacity, require long term management of illness at home, and of nursing care.

34. Health care needs of older persons will be given high priority.

The goal should be good affordable health services, very heavily subsidized for the poor and a graded system of user charges for others. It will be necessary to have a judicious mix of public health services, health insurance, health services provided by not-for-profit organisations including trusts and charities, and private medical care. While the first of these will require greater State participation, the second category will need to be promoted by the State, the third category given some assistance, concessions and relief, and the fourth encouraged but subjected to some degree of regulation, preferably by an association of providers of private care.

35. The primary health care system will be the basic structure of public health care. It will be strengthened and oriented to be able to meet the health care needs of older persons as well public health services, preventive, curative, restorative and rehabilitative, will be considerably expanded and strengthened, and geriatric care facilities provided at secondary and tertiary levels. This will imply much larger public sector outlays, proper distribution of services in rural and urban areas, and much better health administration and delivery systems.

36. The development of health insurance will be given high priority to cater to the needs of different income segments of the population and have provision for varying contributions and benefits. Packages catering to the lower income groups will be entitled to state subsidy. Various reliefs and concessions will be given to health insurance to enlarge the base of coverage and make them affordable.

37. Trusts, charitable societies and voluntary agencies will be promoted, encouraged and assisted by way of grants, tax relief and land at subsidised rates to provide free beds, medicines and treatment to the very poor elder citizens, and reasonable user charges for the rest of the population.

38. Private medical care has expanded in recent years offering the latest medical treatment facilities to those who can afford it. Where land and other facilities are provided at less than market rates, bodies

representing private hospitals and nursing homes will be requested to direct their members to offer a discount to older patients. Private general practitioners will be extended opportunities for orientation in geriatric care.

39. Public hospitals will be directed to ensure that elderly patients are not subjected to long waits and visits to different counters for medical tests and treatment. They will endeavour to provide separate counters and convenient timings on specified days. Geriatrics wards will be set up.

40. Medical and para-medical personnel in primary, secondary and tertiary health care facilities will be given training and orientation in health care of the elderly. Facilities for specialisation in geriatric medicine will be provided in the medical colleges. Training in nursing care will include geriatric care. Problems of accessibility and use of health services by the elderly arise due to distance, absence of escort and transportation. Difficulties in reaching a public health care facility will be addressed through mobile health services, special camps and ambulance services by charitable institutions and not for profit by health care of organisations. Hospitals will be encouraged to have a separate Welfare Fund which will receive donating and grants for providing free treatment and medicines to poor elderly patients.

41. For the old who are chronically ill and are deprived of family support, hospices supported or assisted by the State, public charity, and voluntary organisations will be necessary. These are also needed to cater to cases of abandonment of chronically ill aged patients admitted to public hospitals.

42. Assistance will be given to geriatric care societies for the production and distribution of instruction material on self care by older persons. Preparation and distribution of easy-to-follow guidance material on health and nursing care of older persons for the use of family care givers will also be supported.

43. Older persons and their families will be given access to

educational material on nutritional needs in old age. Information will be made available on the foods to avoid and the right foods to eat. Diet recipes suiting tastes of different regions which are nutritious, tasty, fit into the dietary pattern of the family and the community, are affordable and can be prepared from locally available vegetables, cereals and fruits, will be disseminated.

44. The concept of healthy ageing will be promoted. It is necessary to educate older persons and their families that diseases are not a corollary of advancing age nor is a particular chronological age the starting point for decline in health status. On the contrary, preventive health care and early diagnosis can keep a person in reasonably good health and prevent disability.

45. Health education programmes will be strengthened by making use of mass media, folk media and other communication channels which reach out to different segments of the population. The capacity to cope with illness and manage domiciliary care will be strengthened. Programmes will also be developed targeting the younger and middle age groups to inform them how life styles during early years affect health status in later years. Messages on how to stay healthy for the entire life span will be given. The importance of balanced diets, physical exercise, regular habits, reduction of stress, regular medical check up, allocation of time for leisure and recreation, and pursuit of hobbies will be conveyed. Programmes on yoga, meditation and methods of relaxation will be developed and transmitted through different channels of communication to reach diverse audiences.

46. Mental health services will be expanded and strengthened. Families will be provided counselling

facilities and information on the care and treatment of older persons having mental health problems.

47. Non-governmental organisations will be encouraged and, assisted through grants, training and orientation of their personnel, and various concessions and relief to provide ambulatory services, day care and health

care to complement the efforts of the State.

SHELTER

48. Shelter is a basic human need. The stock of housing for different income segments will be increased Housing schemes for urban and rural lower income segments will earmark 10 percent of the houses/house sites for allotment to older persons. This will include Indira Awas Yojana and other schemes of the government. Earning persons will be motivated to invest in their housing so that they have no problems of shelter when they grow old. This will require speedy urban land development for housing, time bound provision of civic services and communication links, availability of loans at reasonable rates, easy repayment instalments, time bound construction schedules and tax reliefs. Development of housing has to be a joint endeavour of public and private sectors and require participation of Housing Development Boards, civic authorities, housing finance institutions and private developers and builders. Older persons will be given easy access to loans for purchase of housing and for major repairs with easy repayment schedules.

49. Layouts of housing colonies will have to respond to the life styles of the elderly. It will have to be ensured that there are no physical barriers to mobility, and accessibility to shopping complexes, community centres, parks and other services is safe and easy. A multi-purpose centre for older persons is a necessity for social interaction to meet other needs. It will therefore, be necessary to earmark sites for such centres in all housing colonies.

Segregation of older persons in housing colonies has to be avoided as it prevents interaction with the rest of the community. Three or four storeyed houses without lifts are unfriendly to older persons, tend to isolate them, restrains their movement outside the home, and are a serious barrier to access to services. Preferences will be

given to older persons in the allotment of flats on the ground floor.

50. Group housing of older persons comprising flatlets with common

service facilities for meals, laundry, common room and rest rooms will be encouraged. These would have easy access to community services, medicare, parks, recreation and cultural centres.

51. Education, training and orientation of town planners, architects and housing administrators will include modules on needs of older persons for safe and comfortable living.

52. Older persons and their families will be provided access to information on prevention of accidents and on measures which enhance safety, taking cognisance of reduced physical capacity and infirmities.

53. Noise and other forms of pollution affect children, the sick and older persons more adversely. Norms will be laid down and strictly enforced.

54. Civic authorities and bodies providing public utilities will be required to give top priorities to attending complaints of older persons. Payment of civic dues will be facilitated. Older persons will be given special consideration in promptly dealing with matters relating to transfer of property, mutation, property tax and other matters. Harassment and abuses in such cases will be checked.

EDUCATION

55. Education, training, and information needs of older persons will be met. These have received virtually no attention in the past. Information and educational material specially relevant to the lives of older people will be developed and widely disseminated, using mass media and non-formal communication channels.

56. Discriminations, if any, against older persons for availing opportunities for education, training and orientation will be removed. Continuing education programmes will be encouraged and supported. These would cover a wide spectrum ranging from career development to creative use of leisure, appreciation of art, culture and social heritage, and imparting skills in community, work and welfare activities. Assistance of open universities will be sought to develop packages using

distance learning techniques. Access of older persons to libraries of universities research institutions and cultural centres will be facilitated.

57. Educational curriculum at all stages of formal education as also non-formal education programmes will incorporate material to strengthen intergenerational bonds and mutually supporting relationships. Interactions with educational institutions will be facilitated whereby older persons with professional qualifications and knowledge in science, arts ,environment, socio-cultural heritage, sports and other areas could interact with children and young persons. Schools will be encouraged and assisted to develop out-reach programmes for interacting with older persons on a regular basis, participate in the running of senior citizens centres and develop activities in them.

58. Individuals of all ages, families and communities will be provided with information about the ageing process and the changing roles, responsibilities and relationships at different stages of the life cycle. The contributions of older persons inside the household and outside will be highlighted through the media and other forums and negative images, myths and stereotypes dispelled.

WELFARE

59. The main thrust of welfare will be to identify the more vulnerable among the older persons such as the poor, the disabled, the infirm, the chronically sick and those without family support, and provide welfare services to them on a priority basis. The policy will consider institutional care as the last resort, when personal circumstances are such that stay in old age homes becomes absolutely necessary.

60. Non-institutional services by voluntary organisations will be promoted and assisted to strengthen the coping capacity of older persons and their families. This has become necessary since families, as they become smaller and women work outside the home, have to cope with scarcity of full time care givers. Support services will provide some relief through sharing of the family's caring responsibilities.

61. Assistance will be provided to voluntary organisations by way of grants-in-aid for construction and maintenance of old age homes. Those for the poor will be heavily subsidised. It is important that such institutions become lively places of stay and provide opportunities to residents to interact with the outside world. Non-governmental organisations will be encouraged to seek professional expertise in the designing of old age homes, keeping in view needs of group living at this stage of the life cycle and the class of clients they serve. Minimum standards of services in such homes will be developed and facilities provided for training and orientation of persons employed in these homes.

62. Voluntary organisations will be encouraged and assisted to organise services such as day care, multi service citizen's centres, reachout services, supply of disability related aids and appliances, assistance to old persons to learn to use them, short term stay services and friendly home visits by social workers. For old couples or persons living on their own, helpline, telephone assurance services, help in maintaining contacts with friends, relatives and neighbours and escorting older persons to hospitals, shopping complexes and other places will be promoted for which assistance will be given to voluntary organisations. Older persons will be encouraged to form informal groups of their own in the neighbourhood which satisfy the needs for social interaction, recreation and other activities. For a group of neighbourhoods villages, the formation of senior citizens's forums will be encouraged.

63. A Welfare Fund for older persons will be set up. It will obtain funding support from government, corporate sector, trusts, charities, individual donors and others. Contributions to the Fund will be given tax relief .States will be expected to establish similar Funds.

64. The need for plurality of arrangements for welfare services is recognised. Government, voluntary organisations and private sector agencies all have a place, the latter catering to those who have the means and desire better standards of care.

PROTECTION OF LIFE AND PROPERTY

65. Old persons have become soft targets for criminal elements. They also become victims of fraudulent dealings and of physical and emotional abuse within the household by family members to force them to part with their ownership rights. Widow's rights of inheritance occupancy and disposal are at times violated by their own children and relatives. It is important that protection is available to older persons. The introduction of special provisions in IPC to protect older persons from domestic violence will be considered and machinery provided to attend all such cases promptly. Tenancy legislation will be reviewed so that the rights of occupancy of older persons are restored speedily.

66. Voluntary organisations and associations of older persons will be assisted to provide protective services and help to senior citizens through helpline ser-vices, legal aid and other measures.

67. Police will be directed to keep a friendly vigil on older couples or old single persons living alone and promote mechanisms of interaction with neighbourhood associations. Information and advice will be made available to older persons on the importance of keeping contacts on phone with relatives, friends and neighbours and on precautions to be taken on matters such as prevention of unauthorised entry, hiring of domestic help, visits of repair and maintenance persons, vendors and other, and the handling of cash and valuables.

OTHER AREAS OF ACTION

68. There are various other areas which would need affirmative action of the State to ensure that policies and programmes reflect sensitivity to older persons. Among these are issue of identity cards by the administration; fare concessions in all modes of travel; preference in reservation of seats and earmarking of seats in local public transport ; modifications in designs of public transport vehicles for easy entry and exit ; strict enforcement of traffic discipline at zebra crossings to facilitate older persons to cross streets-, priority in gas and telephone connections and in fault repairs; removal of physical barriers to facilitate easy

movement; concessions in entrance fees in leisure and entertainment facilities: art and cultural centres, and places of tourist interest.

69. Speedy disposal of complaints of older persons relating to fraudulent dealings, cheating and other matters will go a long way in providing relief to them. Machinery for achieving this objective will be put in place.

70. Issues pertaining to older persons will be highlighted every year on the National Older Person's Day. The year 2000 will be declared as the National Year for Older Persons. Activities during the year will be planned and executed with the participation of different organisations.

71. Facilities, concessions and reliefs given to older persons by the Central and State Governments and the agencies will be compiled, updated at regular intervals and made available associations to older persons for wide dissemination.

NON - GOVERNMENTAL ORGANISATIONS

72. The State alone cannot provide all the services needed by older persons. Private sector agencies cater to a rather small paying segment of the population. The National Policy recognises the NGO sector as a very important institutional mechanism to provide user friendly affordable services to complement the endeavours of the State in this direction.

73. Voluntary effort will be promoted and supported in a big way and efforts made to remedy the current uneven spread both within a state and between states. There will be continuous dialogue and communication with NGOs on ageing issues and on services to be provided. Networking, exchange of information and interactions among NGOs will be facilitated. Opportunities will be provided for orientation and training of manpower. Transparency, accountability, simplification of procedures and timely release of grants to voluntary organisations will ensure better services. The grant-in-aid policy will provide incentives to encourage organisations to raise their own resources and not become dependent only on government funding for providing services on a

sustainable basis.

74. Trusts, charities, religious and other endowments will be encouraged to expand their areas of concern to provide services to the elderly by involving them on ageing issues.

75. Older persons will be encouraged to organise themselves to provide services to fellow senior citizens thereby making use of their professional knowledge, expertise and contacts. Initiatives taken by them in advocacy, mobilisation of public opinion, raising of resources and community work will be supported.

76. Support will be provided for setting up volunteer programmes which will mobilise the participation of older persons and others in community affairs, interact with the elders and help them with their problems. Volunteers will be provided opportunities for training and orientation on handling problems of the elderly and kept abreast of developments in the field to promote active ageing. Volunteers will be encouraged to assist the home bound elderly, particularly frail and elderly women and help them to overcome loneliness.

77. Trade unions, employers' organisations and professional bodies will be approached to organise sensitivity programmes for their members on ageing issues, and promote and organise services for superannuated workers.

REALISING THE POTENTIAL

78. The National Policy recognises that 60+ phase of life is a huge untapped resource. Facilities will be made available so that this potential is realised and individuals are enabled to make the appropriate choices.

79. Older persons, particularly women, perform useful but unsung roles in the household. Efforts will be made to make family members appreciate and respect the contribution of older persons in the running of the household specially when women, too, are working outside the home. Special programmes will be designed and disseminated through the media targeted at older persons so that they can enrich and update

their knowledge, integrate tradition with contemporary needs and transmit more effectively socio-cultural heritage to the grandchildren.

FAMILY

80. Family is the most cherished social institution in India and the most vital non-formal social security for the old. Most older persons stay with one or more of their children, particularly when independent living is no longer feasible. It is for them the most preferred living arrangement and also the most emotionally satisfying. It is important that the familial support system continues to be functional and the ability of the family to discharge its caring responsibilities is strengthened through support services.

81. Programmes will be developed to promote family values sensitise the young on the necessity and desirability of inter-generational bonding and continuity and the desirability of meeting filial obligations. Values of caring and sharing need to be reinforced. Society will need to be sensitised to accept the role of married daughters in sharing the responsibility of supporting older parents in the light of changing context where parents have only one or two children, in some situations only daughter. This would require some adjustment and changes in perceptions of in-laws in regard to sharing of caring responsibilities by sons and daughters as a corollary to equal rights of inheritance and the greater emotional attachment that daughters have with their parents.

82. State policies will encourage children to co-reside with their parents by providing tax relief, allowing rebates for medical expenses and giving preference in the allotment of houses, persons will be encouraged to go in for long term savings instruments and health insurance during their earning days so that financial load on families can be eased. NGOs will be encouraged and assisted to provide services which reach out to older persons in the home or in the community. Short term stay-in facilities for older persons will be supported so that families can get some relief when they go out. Counselling services will be strengthened to resolve intra-familial stresses.

RESEARCH

The importance of a good data base on older persons is recognised. Research activity on ageing will require to be strengthened. Universities, medical colleges and research institutions will be assisted to set up centres for gerontological studies and geriatrics. Corporate bodies, Banks, Trusts and Endowments will be requested to institute Chairs in Universities and medical colleges in gerontology and geriatrics. Funding support will be provided to academic bodies for research projects on ageing. Superannuated scientists will be assisted so that their professional knowledge can be utilised.

84. An interdisciplinary coordinating body on research will be set up. Data collecting agencies will be requested to have a separate age category 60 years and above. Professional associations of gerontologists will be assisted to strengthen research activity, disseminate research findings and provide a platform for dialogue, discussion, debate and exchange of information.

85. The necessity of a national institute of research, training and documentation is recognised. Assistance will be given for setting up resource centres in different parts of the country.

TRAINING OF MANPOWER

86. The Policy recognises the importance of trained manpower. Medical colleges will be assisted to offer specialisation in geriatrics. Training institutions for nurses and for the paramedical personnel need to introduce specific courses on geriatric care in their educational and training curriculum. Inservice training centres will be strengthened to take up orientation courses on geriatric care. Assistance will be provided for development of curriculum and course material. Schools of Socials Work and University Departments need to give more attention in their curriculum to issues relating to older persons, intervention strategies and organisation of services for them. Facilities will be provided and assistance given for training and orientation of personnel of non-governmental organisations providing services to older persons. Exchange

of training personnel will be facilitated.

87. Assistance will be given for development and organisation of sensitisation programmes on ageing for legislative, judicial and executive wings at different levels.

MEDIA

88. The National Policy recognises that media have a very important role to play in highlighting the changing situation of older persons and in identifying emerging issues and areas of action. Creative use of media can promote the concept of active ageing and help dispel stereotypes and negative images about this stage of the life cycle. Media can also help to strengthen intergeneration bonds and provide individuals, families and groups with information and educational material which will give better understanding of the ageing process and of ways to handle problems as they arise.

89. The Policy aims to involve mass media as well as informal and traditional communication channels on ageing issues. It will be necessary to provide opportunities to media personnel to have access to information apart from their own independent sources of information and reporting of field situations. Their participation in orientation programmes on ageing will be facilitated. Opportunities will be extended for greater interaction between media personnel and persons active in the field of ageing.

IMPLEMENTATION

90.-The National Policy on Older persons will be very widely disseminated for which an action plan will be prepared so that its features remain in constant public focus.

91. The Policy will make a change in the lives of senior citizens only if it is implemented. While the government and its principal organs has some basic, responsibilities in the matter, other institutions as well as individuals will need to consider how they can play their respective roles for the well-being of older persons. Collaborative action will go a

long way in achieving a more humane society which gives older persons their legitimate place. Apex level organisations of older Persons have special responsibilities in this regard so that they can function as a watchdog, energise continuing action, mobilise public opinion and generate pressure for implementation of the Policy.

92. The Ministry of Social Justice and Empowerment will be the nodal Ministry to coordinate all matters relating to the implementation of the Policy. A separate Bureau of Older Persons will be set up. An Inter-Ministerial Committee will coordinate matters relating to implementation of the National Policy and monitor its progress. States will be encouraged to set up separate Directorates of Older Persons and set up machinery for coordination and monitoring.

93. Five Year and Annual Action Plans will be prepared by each Ministry to implement aspects which concern them. These will indicate steps to be taken to ensure flow of benefits to older persons from general programmes and from schemes specially formulated for their well-being. Targets will be set within the framework of a time schedule. Responsibility for implementation of action points will be specified. The Planning Commission and the Finance Ministry will facilitate budgetary provisions required for implementation. The Annual Report of each Ministry will indicate progress achieved during the year.

94. Every three years, a detailed review will be prepared by the nodal Ministry on the implementation of the National Policy. There will be non-official participation in the preparation of the document. The review will be a public document. It will be discussed in a National Convention. State Governments and Union Territory Administrations will be urged to take similar action.

95. An autonomous National Council for older Persons headed by the Minister for Social Justice & Empowerment will be set up to promote and co-ordinate the concerns of older persons. The Council will include representatives of relevant Central Ministries and the Planning Commission. Five States will be represented on the Council by rotation.

Adequate representation will be given to non-official members representing Non-Government Organisations, Academic Bodies, Media and Experts on Ageing issues from different fields.

96. An autonomous registered National Association of Older Persons(NAOPS) will be established to mobilise senior citizens, articulate their interests, promote and undertake programmes and activities for their well being and to advise the Government on all matters relating to the Older Persons. The Association will have National, State and District level offices and will choose its own office bearers. The Government will provide financial support to establish the National and State level Offices while the District level Offices will be established by the Association from its own resources which may be raised through Membership subscriptions, donations, and other admissible means. The Government will also provide financial assistance to the National and State level Offices to cover both recurring as well as non-recurring administrative costs for a period of 15 years and thereafter the Association is to be expected to be financially self-sufficient.

97. Panchayati Raj institutions will be encouraged to participate in the implementation of the National Policy, address local level issues and needs of the ageing and implement programmes for them. They will provide Forums for discussing concerns of older persons and activities that need to be taken. Such forums will be encouraged at panchayat, block and district level. They will have adequate representation of older women. Panchayats will mobilise the talents and skills of older persons and draw up plans for utilising these at the local level. Amongst others, the help of the Social Justice Committees of the village panchayats will be taken to advocate different measures for giving effect to the policy.

98. In order to ensure effective implementation of the policy at different levels, from time to time the helps of experts of public administrations shall be taken to prepare the details of the organisational set up for the implementation, coordination and monitoring of the policy³⁷.

In some countries the aged are shown due respect and courtesy and

properly taken care of. Like Japan observes 15 September as "Grand Parents day" when the grand children wish their elders with flowers and offer gifts to them. In China it is traditional to respect the elders. Taiwan has declared the ninth day of Ninth Lunar month of the year (traditional Double Nine Festival) for the nation to show respect for the elderly population. In the United States of America, the month of May is officially proclaimed "Older Americans Month". In Canada, United Senior Citizens of "Ontario" celebrate June as "Senior Citizens Month" called jubilagerian, celebration of age. Egypt had proposed at the Fourteenth International Conference of Gerontology held at Acapulco (Mexico) in 1989 to set aside the day of 30th November each year to honour the elderly. The Council of Helpage International at its meeting held in New Delhi on October 6, 1990 has urged the United Nations to launch an International Day for the elderly people. In order to get the attention of the International community and the people of various countries on the problems of the aged and launch various programmes of their welfare, the United Nations should declare International year and a day for the aged as it did in the case of children, women and youth which motivated the world community and national governments to introduce programmes of their welfare on an unprecedented scale.

REHABILITATION OF THE ELDERLY

Elderly people (Senior citizens) are endowed with experience of life and have enormous potentials as also capacity to lead. The proportion of elderly persons above the age group 60 constitute 6.5% of the total population. By the turn of the century India will have 75 million people over 60 years of age. The aged are vulnerable to high morbidity and mortality. Limited data available on the subject indicate that over half of them have one or the other ailment at any point in time. In rural settings, over 66% of aged manifested one or the other ailment. However one need to have more hard data for planning rehabilitation programmes. The mortality effects are also high.

Rehabilitation of the aged must take into consideration the broad

areas like health or physical, social, economic as also gainfully deployment of aged.

PHYSICAL REHABILITATION

Majority of the elderly (66%) have one or the other ailment; despite these ailments they lead socially useful and productive life. Physical rehabilitation essentially should aims at best use of remaining physical capacities of elderly. Basic minimum target should be to achieve self reliance for day to day physical activities so essential for life processes. Capacity building amongst elderly people is an exercise of enabling them to lead a socially useful and productive life. These exercises should primarily be attempted by the elderly themselves and the family should provide active support.

Elder to Elder Programme: Social groups of elderly, people in urban and rural areas can spearhead the activities on voluntary basis. Voluntary organisations of elderly can pool experiences for sharing and build capacities through training of their peer groups. Lot of free time is available with elders for such activities.

Family continues to be strongest institution in India. It should support the elderly and fulfill its primary obligations of physical rehabilitation. Training of National Services Schemes Volunteers in the school and colleges and other family members on the issues of simple appropriate primary level rehabilitation techniques can go a long way.

Govt. Institutions voluntary organizations and professional bodies are active in organizing free eye camps to restore eye sight through cataract camps, providing hearing aids and other measures. The diseases encountered by elders are, by and large of chronic nature requiring long and continued care to prevent disabilities. Studies in many countries and our own observations confirm the fact that only a small proportion of the elderly population need institutional care for rehabilitation. The best rehabilitation of aged is to keep them active in home environment in open community life.

At present elderly people get services through system of subcentres, primary health centres and referral hospitals. Utilization is not optimal because of several limiting factors. In rural areas 8.56% of elderly people used the services against 40.75% of children and 45.13% of young people,

SOCIAL AND PSYCHOLOGICAL REHABILITATION

The best environments for aged happen to be home and community, in our situation. The old age homes serve a limited purpose. Process of adaptation is required on the part of family and elder. The elders should be viewed as wisdom banks: and should be considered as asset for family. Because of breaking down of joint family system, migration of able bodied to urban and industrial areas leaving the elderly in the villages and if they follow their adult children to the cities, they settle in slums and uncontrolled settlements where they have, no role status or identity. This creates social and psychological problems. Over 89% of elderly men and women in rural areas: according to our study, are well adjusted in their families and do not have any problem. Only 11% have the feeling of neglect and uncared for in the family. It is hard for elders to move to new location or institution for a new life in environment. Old is gold for them and they adjust best in the environments they have lived over a long time and derive pleasure in belongingness, familiarity, identity and mixing with peer group in their neighbourhood.

ECONOMIC REHABILITATION

75% of elderly persons are economically active, in the home and field by doing petty works in these settings within their limited capacities. They sustain themselves and enjoy respect and keep healthy by this way. Many elders waste money on smoking, changing ways of life can preserve health and saves money. The retired persons keep some kind of bank balance and get pension and enjoy better respect than those who have no source.

Elderly who do not have regular source of income are looked down upon and uncared for. If there are 3 or 4 sons, the trouble is much

more, conflict is much more as to who will shoulder the responsibility for elder. State government have initiated old age pension scheme to provide some economic support and to enhance the respect of elders in the family and community. This benefit though meagre, is welcome initiative on the part of government

Besides these as a measure of economic rehabilitation, the elderly persons can be supported by utilizing their talents in part time jobs like adult education, health guides, traditional birth attendants, tuition for students and counselling services on several subjects depending upon their talents. Thus to harness the services of elder people by part time employments, as also voluntary and social work for human resource developments can go a long way.

This vast resource of knowledge, experience, expertise, creativity needs to be used increasingly and many elders are ready to serve the fellow being with honour and dignity. Oldmen associations, religious and cultural groups, services groups can enrich the interest of each other group. Voluntary organization like HELPAGE International runs adoption scheme, but the very approach of 'Adoption' in our settings may not be viewed as positive and may be abortive and not viable proposition in rural areas.

For rehabilitation of aged the social, economic vocational and psychological component are probably much more important than medical components.

Some basic recommendations for rehabilitation are as under:-

(1) The elderly people should be part and parcel of the normal stream of life and society. They should not be isolated to elderly homes or institutions.

(2) Responsibility of organizing elderly people should rest with family and elderly themselves mainly through voluntary efforts and some support from government. Help Age India is one such example. Family and community should shoulder the primary responsibility to

rehabilitation elderly persons in terms of social psychological adjustment and economic support.

(3) Diversification of capacity building as per need and local resources. No uniform strategy can work. The Strategy for rural areas, urban slums and urban elites has to be different.

(4) The school children, youth and adult members of the society should be enlightened to develop respect and sense of responsibility towards elders. This can be done through curriculum as also through open universities and non-formal system of education.

(5) Mass media and other media should adequately project the problems of the elders to prepare mass support and generate wide spread awareness.

(6) National policy for elderly people (for a segment of population) may not be considered as viable option. Sectorial programmes for elders needs to be coordinated well to harness greater degree of acceptance and support and harmony.

(7) Non government organization (Professional Bodies and others) can better further the cause of elderly people and generate capacity building programme.

(8) Data based information on the problems of elderly is too scanty. hence operational research studies and case studies should be encouraged in this area. Available information should be coordinated and disseminated to benefit the cause of elderly.³⁸

OBJECTIVES OF STUDY:

The present study was concerned to study the social status and problems of elderly women. The objectives of study were the following :-

1. To study socio-demographic features of respondents.
2. To identify social status and social, economical, psychological and physical problems of elderly women.

38. Lal S., Rehabilitation of the Rural Elderly, HCPT/NIPHC Lecture - Series in Geriatrics, edited by : Dr. P. C. Bhatla, New Delhi, 2000.

3. To study the role of family and self care practices by the elderly women.
4. To study the various issues in relation to the elderly women.
5. To seek the opinion of respondents regarding various old age welfare programme provided by the Government and Non Government Organization.



RESEARCH METHODOLOGY

As the human being is the highest composition of God, in the same way human society and various social phenomena are the highest contribution man. The human being is intellectual, full of curious and has thrust of knowledge, therefore it is truely said that human not only studies the nature but also he studies about himself. The study of earth, plants, winds, river and sea related study presents wonderful experiences, knowledge before him and fulfil his store of art and science, but the study about himself, his society, his behaviour or social events contents for human are very interesting, excessive, wonderful and full of unique in nature, but this sorts of study is not by subjective nature, but is truth can be attained only by observation ,experiment and emperical based activities. In relation to social events, the observation of truth is social research ,*"Research in all fields of human activities means continued search for knowledge and understanding. But,not all knowledge and understanding is scientific. Scientific research is essentially made up of two elements - (i) Observation by which knowledge of certain facts is obtained through sense perception. (2) Reasoning by which the meaning of these facts,their interrelation, and their relation to the existing body of scientific knowledge are ascertained as far as the existing state of knowledge and investigator's ability permit."*¹

These both elements; if available in investigation of social facts, then it is called social resarch. In this outlook social research is emperical method to solve any social problem, to verify any hypothesis, to seek

1. Mukherjee, R.N. (2001) VIII ed. Social research and statistics,Matraashish,Tilak colony, Subhash nagar,p.1.

causes of new problem, and to co-relate the cause and effect relationship of various new problems. This emperical method ought to be such which fulfil the terms and conditions of science and with the help of it subject of reserch may be verified. In brief, for the sake of new knowledge systematic endivours are called social research.

Now it is clered that social research according to regulations of science, indicates about those human activities, which strengthen our knowledge pertaining to cause and effect of any phenomenon. The more explorating thing about social research is that method which is based on observation, classification and analysis of information. In this context, Mrs. Young said that "*We may define social research as a scientific undertaking which, by means of logical and systematised methods, aims to discover new facts or old facts, and to analyse their sequences, inter-relationships, causal explanations and the natural laws which govern them.*"² Therefore Moser said that, "*Systematised investigation to gain new knowledge about social phenomenon and problems, we can call social research.*"³

Social research is not a simple work that is why is each individual cannot perform it. Merely bookish knowledge is not sufficient for it. Some other internal and external characteristics are essential,because social research is concerned with social problems;and social problems are abstract,changeable,complex and individual oriented. Thus,their study is difficult than that of natural sciences. It is unique that to study the social problem, is the study of human by human as the subject of this research study, " Status and problems of elderly women.

UNIVERSE OF STUDY :

During research every researcher faceses problems of selecting

2. Pauline, V. Young, Scientific Social Survey & Research, Asia Publication House, Bombay, 1960, p.44.

3. C.A. Moser, Survey Methods in Social Investigation, Heinemann, London,1961, p.3

research area. In context of research area researcher have different views; some says it should be small / limited while others say it should be wide and big, but in scientific view it should neither to small nor to big and wide because (1) the time limitation for research work is 2 year and it has to be completed within the time (2) if the area is too big and wide researcher has to waste his time, money and has to do more labour in order to collect data, that is why research area should neither be too small nor too big.

Among the town of north India, Jhansi has remarkable place in Indian history, especially in the lore of its freedom struggle. It is associated with the illustrious and legendary figure of Maharani Laxmi Bai who fought valiantly against the British Empire in 1957 uprising and made a glorious place for themselves in the annals of country's war of independence.

Under the regime of British, Jhansi developed as an administrative railway and military centre. It is the administrative seat of the commissioner of Jhansi Division. Jhansi is a major railway junction on the north-south main truck routes and the Jhansi - Babina military centre.

The complex is one of the largest in country but its hinterland was and continues to be economically underdeveloped. Educationally it remained neglected for a long time. Although in recent years it has been trying to catch-up, with the progress in other parts of the country.

Jhansi district lies in the extreme north-west corner of U.P. between $24^{\circ} 11'$ and $25^{\circ} 57'$ north latitude and $78^{\circ} 10' - 79^{\circ} 25'$ east longitude. In the west and north, its boundary is contiguous with that of M.P. In point of fact, culturally it forms a part of Bundelkhand region most of

which lies in M.P., the campus area of district Jhansi is 5024 sq. kms.

Table No. 1(3)

Population of Jhansi in Decades and Growth Rate

Year	Sexwise distribution of Population			Decadal Growth Rate
	Male	Female	Total	
1971	555252	462761	1018013	-
1981	660664	569621	1230265	20.80
1991	700735	559529	1260264	21.62
2001	736926	569128	1306054	22.60

The change in population or the increase in population in the two decades has been stated in the following table. In both categories of male and females insite of being large on the basis of area which constitutes of five Tehsil the population growth is less.

Table No - 1(4)

Male & Female Ratio and Decadal Growth Rate

Year	Male	Female	Total	Decadal Growth	Female Per 1000 Male
1971	555242	462761	1018013	-	860
1981	690644	569621	1260265	242252	884
1991	736926	596128	1333054	272789	832
2001	830075	695127	1525202	234948	834

On the evaluation of table we come to know that in the year 1971 total population of male were 555242 and 462761 of women which raised to 690644 of men and 569621 of women in the year 1981, in the same way the year 1971 to 1981 the total change in poulation was 242252. In the year 1991 the population of males were 736926 and that

of females were 596128. In the same way the change in decade was 272789 between the year 1981 to 1991, in the year 2001 ratio of female to male was 834.

Table No - 1(5)**Distribution of Rural / Urban Population**

Details	Male	Female	Total
1. Census 1981			
Rural	310035	393427	703462
Urban	189260	176051	365311
2. Census 1991			
Rural	524306	429013	953319
Urban	166338	140608	306946
3. Census 2001			
Rural	617887	507607	1125494
Urban	219039	188521	407560

On the basis of following table which shows that there were 310035 males and 393427 females in rural areas. While 189260 males, 176051 females in urban areas in the year 1981 and in the year 1991, 953319 total population were found in rural and 306946 in urban areas. In the year 2001, there were increased number of males in rural areas 617887, females were 507607 and in urban 219039 males and 188521 females.

Table - 1(6)**Division of Population on the basis of age group****(According to special edition of statistical magazine-2001)**

Sl. No.	Age Group (In Years)	Male Population (In %)	Female Population (In %)	Total Population (In %)
1.	0-4	12.3	13.4	12.8
2.	5-9	15.0	14.7	15.0
3.	10-14	14.4	12.7	13.7
4.	15-19	10.2	8.4	9.3
5.	20-24	7.8	8.4	8.0
6.	25-29	6.6	7.4	6.9
7.	30-34	5.5	6.4	5.9
8.	35-39	5.2	6.1	5.5
9.	40-44	5.4	5.4	5.3
10.	45-49	4.3	4.6	4.5
11.	50-54	4.4	3.6	4.1
12.	55-59	2.3	2.7	2.5
13.	60 & above	6.6	6.2	6.5
	Total	100.0	100.0	100.0

On the basis of age factor the whole population has been divided into following age groups 0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59 and 60 and above if we looks the figure of table we find that in the male group 41.7% of the people belongs to the age group of 0-14 year, 24.6% to the age group of 15-29 16.3% are in 30-44 age and that of 17.44 are of 45 and above. In comparison to female which are 40.8% in the age group of 0-14 and 24.2% falls in 15-29, 17.9% in the age group of 30-44 year and lastly in the age group of 45 year and above they were 17.1%. It has been found that in the age group of 60 and above the percentage of male member was 6.6% in

comparison to 6.2% that of women and on the whole the overall percentage of population was 6.5%.

Table No -1(7)
Division of Population on the basis of religion.

Sl. No.	Religion	% of Total Population
1.	Hindu	92.28
2.	Muslim	7.14
3.	Christian	0.03
4.	Sikh	0.03
5.	Buddh	0.06
6.	Parsi	0.35
7.	Others	0.01
	Total	100.00

The whole population of the district can be divided into given class - Hindu, Muslim, Sikh, Christians, Jain, Buddh and other caste. The whole division on the following castes has been stated in the following table.

Following table shows that the majority of population living in Jhansi area belongs to Hindu Religion which was 92.28% and remaining which 7.14% was of Muslim community and the percentage of other religion was 0.03%, 0.03%, 0.06%, 0.35%, and 0.01% of christian, Sikh, Buddh, Parsi and other.

Table No- 1(8)**Division of Population on the basis of Educational Status**

Sl. No.	Detail	% of Educated Male	% of Educated Female	Total
1.	Census 1991	58.5	39.9	49.9
2.	Census 2001	66.1	47.6	57.6

On the basis of above table which shows that in the year 1991 the total percentage of educated males were 58.5% and 39.9% that of females, and the total educated population was 49.9%, in comparison to 66.1% that of male and 47.6% of females and total was 57.6% in the year 2001.

Table No. 1 (9)**Particulars of Medical Facilities in Distt. Jhansi**

The particulars of public sector physicians sanctioned and in position are given discipline wise of Jhansi¹

Allopathy		Ayurvedic/ Unani		Homeopathic		Total	
San.	In position	San.	In position	San.	In position	San.	In position
85	78	21	20	6	3	112	101

The position of private sector physicians in District Jhansi is given below²

Allopathy		Ayurvedic/ Unani		Homeopathic		Total
Dr.Reg.	Privt.Dr	Dr.Reg.	Privt.Dr	Dr.Reg.	Privt.Dr	Dr.Reg. Privt.Dr
583	505	488	468	5	-	116 53

Public sector medical institutions in district Jhansi can be known by following information.³

Allopathy		Ayurvedic/ Unani		Homeopathic		Total
69	40			5		114

RESEARCH DESIGN

Sociological studies are different on several basis. Some are to quench curiosity of man some for getting new knowledge. Some for formulation of hypothesis, some for verification of theme. Some research aimed to describe any social phenomenon, some for solving the social problem, some for purpose of planning, some for evaluation the impact of programme,scheme and planned change. So on these objectives basis, social research are carried out. The objectives of study cannot achieved without orderly action from the begining of the study. This draft is called research design. It means the type of research design is decided in accordance with type of selected problem or hypothesis; so that research

Source - 1 : Director of Health Services, Swasthya Bhawan, Lko, 1993 (Col. 1,2)

Director of Ayurvedic and Unani Lko, 1993 (Col. 3,4)

Director of Homeopathy, 1993 (Col. 5,6)

Source 2. Registrar Cum Secretary, I.M.C., Lko, 1993

Registrar Board of Indian Medicine, Lko, 1993

Registrar Homeopathic Medicine Board, Lko, 1993

Source 3. Economics and Statistical Division State, 1992,

study can get a certain direction and investigator escape to wonder hither and thither.

It has already been social that any social research cannot be conducted without any goal. These goals are formulated before starting study. So pre planning blue print of various activities to be carry out in future is called rerearch design. Ackoff, in this connection says, "*Design in the process of making decision before the situation arises in which the decision is to be carried out.*"⁴ Now it is clear that there are many kinds of social research designs. Every investigator to the objectives of study. That is which type, the nature and objectives become clear, as in Exploratory Design, mostly what are causes of any problem is the objective of research.

The main objective of all researches is achievement of knowledge. This knowledge can be attained by various means. So research designs are also several according to objectives. Mostly, Exploratory ,Descriptive and Experimental research designs are used in sociological studies. In this research study " Explorating Design' is used.Seltiz,Jahoda et. al written about Exploratory design," Exploratory research is necessary to obtainn the experience which will be helpful in formulating relevant hypothesis for more definite investigation."¹ The same type of idea is expressed by ' Hansraj'- Exploratory design is essential to do for special study, for formulation of hypothesis and to obtain related experience related to formulated hypothesis.

To clear the various problems of 'Elderly Women' and their effect, researcher selected this design for her study. For example, if we want to study the elderly women and their problems, then it would be necessary to study various issues which creat problems for elderly women.

Exploratory type of research design becomes a scheme of observing those factors which are responsible for these problems. For the success of their research design investigator studied related literature, (1) contacted all those about whom she heard that they had knowledge about the problems of elderly women. Their experiences become direction for researcher (3) They all created internal motivation and insight and helped in each community, there are various problems, out of them some are simple, some pathological and some are related with individual, which encourage the scholars to study them.

SAMPLING METHOD / SIZE

To estimate about "all" by looking or by examining of "some" is a method of sampling. It is assumption of this technique that the characteristics of 'some' represents the element of 'total' provided the selection of 'some' is carefully done. To look 'all' is inconvenient, expensive and requires more time. Therefore, its unutilise expenses is inadequate. Only representative sample study is best. In social research, use of sampling method is very popular, that's why in the sense of its use, is done by a layman excessively. No one verifies each seed by opening the mouth of bag but merely some seeds are expelted from the bag and checked, then those seeds are evaluated. It is for all the wheat which are in bag. We take care to take these seeds. Seeds are not taken from upper layer of the heap of wheats so that good seeds of wheat, which are kept by businessman on upper side of the heap of wheats because those seeds do not represent all the seeds of wheats of the heaps. That is why there is great need of care. So our more vigilance in this connection is essential to get less deception in the purchase of the wheat. It is only an applied Sampling Technique of social research. Its use is carried out in

emperical study.⁵

Research work can be conducted on the basis of two methods. If we make the basis only the study population or make basis of units for selection. These both methods are called Census and Sampling method. If we want to conduct social survey of school children then we have to interview with every child, it will be called census. In sampling method; we select some students of every class. About sampling method Frank Yaton says, "The term sample should be reserved for a set of units or portion of an aggregate of material which has been selected in belief that it will be representative of the whole aggregate." Goode and Hatt also expresses their views, "A sample, as the name implies, is a smaller representation of a large whole."⁶ In research work sampling technique is one of the best method because this method save lot of time, money, energy of researcher and it gives scope for accurate data.

There are many types of sampling method in which 1. **Random Sampling** is considered as best method of sample selection, because in it every item or unit of universe has an equal opportunity for selection and selection is not influence by personal bias and prejudices of the investigator. Thomas Carson says about random sampling that, "In a random sample the chance of being 'drawn' or 'thrown' is independent of the character of the event."⁷ There are some techniques of random sampling; (i) Lottery method, (ii) Card or Ticket method, (iii) Regular marking method, (iv) Irregular marking method, (v) Tippet method, (vi) Grid method, (vii) Quota method.

5. Mukherjee, Ravindranath (2001), 'Social Research & Statistics', Vivek Publication, 7, U.A. Jawahar Nagar, Delhi, P-279.

6. William J. Goode & Paul K. Hatt, Methods in Social Research, McGraw - Hill Book Company, Inc., New York, 1952, P-209.

7. Thomas Carson, Mc Gromuck, Elementary Social Statistics (1941), P. 224.

2. Purposive Sampling : When there is specific objective and researcher select some units deliberately from the universe is called purposive sampling. *Adolph Jenson rightly said about this sampling, "Purposive sampling denotes the method of selecting a number of groups of units, in such a way that the selected groups together yield as nearly as possible the same averages or proposition as the totality with respect to those characteristics which are already a matter of statistical knowledge"*

3. Stratified Sampling : Prof. Hsin Pao Yang writes about it, "Stratified sampling means taking from the population sub samples which have common characteristics, such as type of farming, size of farms and ownerships, educational attainment, income, sex, social class etc. These elements making up the sub-samples are drawn together and classified as a type of category."⁸

In this research study researcher keeping all the essential points of sampling in consideration, selected 300 elderly women whose account is given in following table randomly.

Table No. 1(12)

S. No.	Name of Caste	Sample Frequency	Sample %
1.	General Caste	50	16.33
2.	Backward Caste	100	33.67
3.	Schedule Caste	75	25.00
4.	Muslims	75	25.00

Due to limitation of time, money and other resources, it was not possible for the investigator to study relatively large sample.

8. Hsin Pao Yang, 'Fact Finding with Rural People', PP 36.37.

SOURCE / TECHNIQUES OF DATA COLLECTION

Without information and data social research and investigation is in reality like a handicap person. The success of research is depended upon how much real, dependable and appropriate informations we collect. The success again depends on reliable sources of data. Therefore, the importance of information and data cannot be rennewated in the field of social research. These information are not of one type, they are also of many forms. The knowledge of different forms of data is essential for successful investigation. From which source, which type of information he can obtain, if does not know then he has to wonder this and that side and his valuable time and labour will be wasted. Thus the knowledge of various source of data is necessary for a research investigator.

In social research various types of data are needful. They are classified in two forms- first, Primary data or information are those fundamental information which are collected in the field by face to face relationship with the respondents about research subject through interview or schedule or direct observation as *Palmer says*, "Such sorts of individuals not only have ability to explain problems related to the subject but also indicate about internal important steps in social processes and observable curves."⁹ Smt. Young classified source of information into two parts - Documentary and Field source.¹⁰

In this resarch study, researcher keeping in mind the problems of elderly women, preferred primary source of data. Field observations were also made the centre of study. Apart from primary information documentary sources - Related books, life sketch, Reports, News paper contents, as an evident,were used because in India there is lack of

9. V.M. Palmer (1982), *Field study in Sociology*, University of Chicago Press, Chicago, 1928, P.57.i

10. Pauline V. Young, "Scientific Social Surveys and Research" 'Asia Publishing house,Bombay, 1960, P-127.

statistical data and if available, they are not adequate. Census data can not be ignored, these reports provide reliable data about socio-economic and cultural aspects of human life, for example, the size of family, sex ratio, caste wise and religions wise information, occupation wise, educational status, age wise distribution, vital statistics among population of our country, these data of census have very importance; politically, socially, economically and commercially.

To observe scientific findings in social research about particular social phenomena, scientific facts are not merely estimates but solid results based on actual facts and exact information. Thus it is clear that the fundamental condition of social research is collection of real information.

Real data can not be collected by imaginary manner. For this scientific devices are essential. It is because of solid and empirical techniques through which data are collected is called techniques of data collection. For scientific analysis and interpretation, those real data are required, to collect them, investigator uses techniques, that is the technique for him. Moser wrote in this connection. "*Techniques are those accepted and systematised devices for a social scientist which are used to obtain reliable facts related to his study.*"¹¹

So the basis of social research is reliable data, information and facts. In Sociology followings are the techniques of the study of social phenomena, as given below :

1. Questionnaire : When respondents are scattered in a wide area. They can not be contacted easily then questionnaire are sent to them by mail along with a request letter. Respondents send them to surveyor.

11. C.A. Moser and C. Kalton (1961), "Survey Method in Social Investigation, P-271.

2. Schedule : Schedule is filled by investigator himself by face to face relationship in the field. It is used all type of respondents technique of data collection.

3. Interview : In which investigator collect information from respondents himself in a homely environment.

4. Observation : This method is used by investigator in real field situation by eye witness. These observation many be participant and non participant in nature.

5. Case Study : In the area of social research, thoe method of data collection are deployed, out of them individual case study method is very important. In the words of Goode and Hatt, "*In case study we submit step by step picture of special types of continuous experiences. In this form in the process of time numerous experiences, social forces and by implication background study of a certain unit full of logic is case study.*"¹²

For direct contact with research area, investigator in this study prior to conduct interview with respondents, she tested schedule in the field and modified the schedule accordingly then schedule was used along with observation method, about which Goode and Hatt explained that, "Investigator selected only Structural questions as well as Dichotomous Questions and Open ended Questions were discarded because there is more time and money is needed for their classification and tabulation.

For the study of individuals attitudes, tendencies sentiments and emotions, only interview technique provide its diagnosis, that is why this technique is superlative in all techniques of data collection. Allport very nicely said," *If we wish to know, what people feel, what do they*

12. William J. Goode & Paul K. Hatt (1952), Methods in Social Research, Mc.Graw Hill Book, Co Inc., New York, P-119.

experience and what do they remember, what are their sentiments and objectives of life, why don't we ourselves ask from them."

Side by side V.M. Palmer also said "The interview constitutes a social situation between two persons by psychological process involved requiring both individuals mutually respond though the social research purpose of the interview calls for a very different response from the two parties concerned."¹³

In this study, investigator used interview schedule method for data collection. For this researcher adopted following process of interview:-

i. Researcher conducted interview with respondents to collect information related to study. She collected data in face to face relationship, communication for the sake of research according to schedule. When the selected sample was not presented then data were collected from the who was on second serial.

ii. **Interview start :** Investigator put up the aims and abjectives of research study before respondents and requested to provide cooperation and she assured them that their information will be kept confidential. She also told them that without their cooperation the problem of elderly women can not be solved. First of all she asked about primary information related to respondent such as name, age, education, occupation etc, after that she asked questions related to study objectives.

iii. **Used encouraging Questions :** During interview process investigator told respondents that their information are very important and helpful in treating the problems of elderly women. Such sorts of sentences were repeated before respondents many time in collection of data.

13. V.M. Palmer, Field Studies in Sociology, 1928, p-170

iv. To remember : Whenever investigator observed that respondent involved in her sentiments and dreams and become away from the main point of subject then investigator reminded and invited her attention toward communication subject.

v. Noting Information : Investigator noted the responses against questions given in schedule to avoid any kinds of obstacles.

Researcher faced some difficulties in collection of data. They were as follows :-

1. Some selected respondents were absent at the time of interview.
2. Some respondents refused to provide interview.
3. Consumed more time.
4. Hiding personal problem.

To deal with above problems, researcher select next serial sample for interview, by contact their family members, respondents who refused to interview, were agreed for interview and respondents who hided personal information were assured not to tell their problems to others, thus they were compel to tell real information about social and psychological problems of old age.

CLASSIFICATION OF DATA

In social research, the basis of research are real information concern with research study. These information when collected, cannot be concluded any result nor understood anything about the subject. The mountain of information does not serve any purpose unless it is not given a systematic form. That is why classification of the information is an essential task. When we classify the collected information on the

basis of their difference and similarity, that is called classification of data. Therefore Robert E Chaddock (1925) wrote, "Classification especially important in the social success because of the many factors affect a given situation and because the measurement show such wide variation."¹⁴ Connor (1936) also highlighted on the classification in the following words, " Classification is the process of arranging things (either actually or rationally) in groups and classes according to their resemblances and affinities and gives expression to the unity of attributes that may subsist amongst a diversity of individuals."¹⁵.

Keeping in the mind above considerations, researcher systemized, synchronized and limited the heapes of information on the basis of big issues, characters, and items of similarity and differences, proximity and distances. In this study, information are classified qualitatively or simple or multqualitatively along with quantitatively also. So that information may be understood easily and thus classification become statistical pure.

TABULATION OF DATA :

In social research, after classification of information, data placed in tables. Actually tabulation after classification is a next step in the process of analysis ,With the help of it information become simple and clear in understanding and statistical data become demonstrable. In this process the data are kept in columns so that data can be understood as Jahoda wrote, "Just as coding is thought of as the technical procedure for the categorization of data, so tabulation may be considered as a part of the technical process in the statistical analysis of data."¹⁶

14. Robert E. Chaddock (1925), Principles and Methods of statistics, Tougghton Mifflin Co Boston. P-43.

15. Connor, L.R., Statistics in Theory and Practice ,1936. P-18.

16. Johoda, Duetsch and W.Cook, Research Methods in Social Relations. P-270.

It is the reason, Ghose (1950) explained, "Tabulation stands for the systematic and scientific presentation of quantitative data in such a form as to elucidate the problem under consideration."¹⁷

That is why Young (1960), "Statistical tabulation is shorthand if statistics; because it fills attraction adequate size, convenience of comparision, clarity appropriate to objetive of study and scientificness."¹⁸

In this research study researcher to make information more easily understandable, she used frequency tables as well as simple tables. She also considered all necessary rules of tabulation such as -(1) write title of tabulations (2) Size according to area of page on which it was drawn, (3) Captions, (4) Write information in columns (5) Keep columns in sequence (6) Division of columns (7) Total and (8) Comments. With this process all collected data are systemised logically and data get clear picture in table. This helps much in statistical analysis. Tabulation makes more simple to comperative interpretation, it also save time and place and make simple scientific analysis work.

ANALYSIS AND INTERPRETATION OF DATA

Scientific analysis assumes that behind the accumulated data there is something more important and revealing than the fact themselves, that well marshalled facts when related to the whole study, have a significant general meaning, from which valid interpretation can be drawn.¹⁹

It is simply the meaning of above statement that the objective of cause and effect cannot clear by collecting a mountain of information unless these collected data are not systemised and then analysis and

17. M.K. Ghose and S.C. Chaudhary, Statistics : Theory and Practice, 1950, P-94.

18. P.V. Young, (1960), Scientific Social Survey and Research, P.-239.

19. Pauline V. Young (1960), Scientific Social Survey and Research, Asia Publication House, Bombay, P.509.

interpretation is not done. The well known Mathematician *Shree Jules Henri Poincare* wrote that, " Science is built with facts as a house is built with stones, but a collection of facts is no more science than a heap of stones is a house."

Therefore, it is essential for science that collected data should be orderly edited and then analysis and interpretation can be done so that true knowledge may be achieved.

The fundamental need of analysis and interpretation of data, if were not systemised they remain meaningless and we can not find any result from data. The research study will remain half if data are not analysed and interpretation so far. It is the only reason that *Smt. Young says*, "*Research is creative aspect of scientific analysis.*"²⁰

Social researcher does not accept that any phenomenon is independent he accepts collected facts, present ideas and inner social philosophy of time ; therefore, any empirical result can be achieved through the careful checking of collected data, their mutual relationship are their context relation with total events.

He can only be succeeded by examining old concepts or seeking challenging situations of new concepts during the process of analysis of data. In this way which insight he gains by process of analysis of informations's, he re examines on the basis of them and achieved a solid base for interpretation of data. That is why real interpretation of data is not possible without adequate analysis of data and without factual interpretation, any result of findings; an investigator can not obtain. According to *Smt. Young*, "*The function of orderly analysis to formulate an solid organisation of a edifice,which helps to keep collected facts in*

20. P.V. Young, op.cit, P.509.

*their proper place, so that general findings can be achieved by them.*²¹

In this way without analysis of data the explanation of cause and effect relationship pertaining to any subject or phenomenon is not possible, nor any progress of science, achievement of real knowledge because on the basis of analysis and interpretation of data real scientific rules can be formulated. Therefore, analysis and interpretation of collected data is essential to test old theories and rules or to certify old theories or rules.

In this research study, researcher through considering above all those guidelines and principles in the mind classified the collected and tabulated them which become simple and like to be understood easily. We uses analysis and interpretation of data which are adopted by sociological research reports the same is used here.

DIAGRAMMATIC PRESENTATION OF DATA

The main aim and objective of statistical method is to provide simple forms to collect data; so that every body can easily understand them as well correct finding can be observed. It is often observed that by classification and tabulation of data we get systematic, orderly and brief form of scattered data. The effective form of these collected data is demonstrate them through pictures. In present days demonstrating data in the kind of bar diagram became an unique art and in the context to locate data in picture form progressing continuously. For general man only data are uninteresting, complex and without attraction, therefore, one does not pay any attention about figures now there is no any interest about figures. On the other hand pictures are more attractive and one can not live without effect of them. It is only the utility and mistry of popularity of data demonstration. Thus *Bodington has to write "A properly constructed diagram appeals to the eye and also to the*

21. P.V. Young, op.cit, P.310.

mind, because it is practical clear and easily understandable even by those unacqainted with the method of presentation."²²

In reality tabulation makes more help in scientfic analysis of data. Yet for a general man, frequencies which are given in tabulation, has no special meaning, because it is difficult for him to understand the internal nature and result. Just its reverse one can understand these figures if they are exhibited in picture form. Side by side pictures provide comparative importance to its visitors'. Therefore, each student of social research should acknowledge with the art of Demonstrating figures in the form of pictures. *Bowley very nicely says," Diagrams are merely an aid to eye and a means of saving time."*²³

In this research study the investigator demonstrated data in the form of simple diagram, multi bar diagrams and pie diagram sothat effective and attractiveprsentation of data may ensured (2) data could be simple in understanding (3) time may be saved (4) data can be easily compared (5) data may simplify in one outlook (6) proved utilisation for research and they could be able to indicate about future.



22. Boddington. Statistics and its application to commerce, p 140.

23. Bowley , Diagram are merely and aid to eye and means of saving time.

CHAPTER-II

REVIEW OF LITERATURE

REVIEW OF LITERATURE

Undoubtedly in the context of social research Review of literature and pre-assessment of studies is important ladder because without doing so researcher can not provide smooth management. Review of literature tells investigator on what subjects, sub topics the studies have been carried out and which types of research designs ,methods and techniques were used in them; along with difficulties faced and resolved by him. It is true that each social problem has relation with country, time and situations. From this points assessment of old studies is not only important but essential too. In the changed environment in present study how many problems may occure, which methods and techniques would be useful to study, which aspects,stages and factors had been studied before and which aspects are left over. Now which perceptive are outstanding to study. How to do study so that research work might be simple and easy in objective form and save money, time and labour. This all is known to researcher by doing review of literature.

Singh, S.P. (1975 : 14) highlighted on the fruitfulness of review of literature. According to him after selection of research topic it is not nearly necessary but essentialities of the research that to ensure assessment in relation to research problem in connection with review of literature pertaining to research topic because it helps -

1 - It develops insight and knowledge in reference of research problem in the mind of researcher.

2 - He learns adequate knowledge in relation to used research methods and techniques.

3 - Review of literature helps in formulating hypothesis and evolving structural schedule.

4 - He dose not commit error to repeat the research problem which has already been carried out.¹

The comment in this direction of **Basin, F.H. (1962 : 40)** is illustrative. He says, In every research study related literature and pre assessment of studies is important stair of research scheme because every research work to be cleared and difficulties resolved by review of literature both the problems of research complexity and unclerness are resolved. It is because of the review of literature,becomes cleared, how to collect valid and reliable information.The following are the usefulness of review of literature.

1- Researcher develops general knowledge about research problem.

2- Research synopsis and usefull methods and techniques are cleared in the mind of researcher how to edit research work.

3- By review of literature investigator correct his mis concepts, daubts and illutions regarding research study ; and side by side work becomes simple to conduct activities. Thus, he gets new oriantetion to develop his insight.² **Borg, J.P. (1963:48)** also highlighted on importance of review of literature. He says,Review of literature enables researcher in such a extent so that he may be able to seek knowledge about already carried out the works which had done and could study them.To do so , investigator gets clear orientation for research on the basis of acquired knowledge and able to select adequate instrument

1. Singh, S.P. (1975:15), Inter relations in an organization, Alok Pub. Pvt. Ltd., Jaipur (Rajasthan).
2. Basin, F.H. (1962:40) Literature Assessment in applied Sciences Mc Millin Co. (Pvt.) Madras, 1962 : 40.
3. Borg, J.P. (1963:48) Observation of literature in social sciences research." Jain brothers & sons, Pub. & Distributers Bombay 1963, Page-48.

and methods".³ On the other hand **Staufer Semmuel (1962:73)** tells that in the absence of excessive study and assessment of old literature , any sort of study is just like a firing in darkness. Without review of literature , research work can not go ahead. Till researcher does not acquire knowledge about the area in which studies have been compiled he can not select the topic of the research nor prepare the synopsis of research study nor provide speed to his investigation. The main reason of the objectives of the study to bring innovation after thinking.⁴

The contribution of **Purosotum (1991:110)** can not be isolated regarding review of literature. According to him, generally there are three domains of knowledge - (1) To collect knowledge (2) Transmit knowledge, (3) Increase knowledge. These three fundamental elements are especially important in research studies. These attempts to keep researcher very nearer to reality. The contribution in the store of knowledge and strengthen in awareness, makes possible the human made endeavours. In the same way in the process of research 'review of literature' is such an important scientific ladder of research enterpreneur which is presented in the uterus of present. In other words individual compose new knowledge through research on the basis of his old awareness and black and white knowledge.⁵

Several studies have been conducted in the field of '**Old Age**' and they have direct or indirect relation with our study whose findings and references are as follows :-

➤ **Ernest Burgers (1960)**, "Much of the disability and ill - health of old people is the result of medical negligence. Now that the

4. Staufer Semmuel; Review : A major steps in investigation in social sciences, American Sociological Review, No.23, Year 1962:73.

5. Rai,S.Purosotum (1991:110), Fundamental elements of social research, Saraswati Pub., Darbhanga (Bihar).

mathematical chance of surviving to old age has increased, a more positive approach to the incurable diseases of this period of life is needed to avert the personal frustrations and community problems that accompany physical disability and mental ill health. The medical profession is beginning to realise that old people do respond to treatment and can recover to function to a surprising degree."⁶

➤ **Davis (1977)** argues that, "From a societal point of view , the country side is better place for aged persons to be. Their skills are more useful in a rural area, less expensive care is needed and the milieu is free some of the disease of old age, such as emphysema,obtaining part time and causal jobs in agricultural regions as in villages is less impeded by union and Government . This issue also needed to be kept in mind while analysing the problems of senior citizens."⁷

➤ **Institute of Social Work Delhi (1977:124)** has surveyed on status of elderly persons in the families of New Delhi and found the following facts :-

- (i) In 37% families the status of aged was not as per their expectation.
- (ii) 49.3% survey sample of aged were having no income of their own that's why they have to remain dependent on the family members. All the aged were found sad and worried for their future.
- (iii) 42.5% surveyed aged were pensioner and were capable to bring

6. Burgess, E.W. (ed.),1960 : Family Structure and Relationship in Aging and Western Culture, University of Chicago Press, Chicago.

7. Davis K; The effect of out migration on Regions of origin, In: Brown A.A. and neuberger E (eds.) Internal Migration. A Comparative Perspective, Academic Press New York, 1977.

up themselves and their respect and importance in family was also more in comparison to who are not getting pension.

(iv) Study shows 36.5% of aged have normal daily routine and they contribute in the household works according to their capability.

(v) The pensioner respondent has accepted that a week before getting of their pension the other family members look after them and works according to their concern and as soon as the pension is delivered them the concern of the family members towards them changes unexpectedly.

(vi) Aged female respondents clearly accepted that they often use to serve their grand children which changes their mood and behaviour. 70.67% respondents said that their life has no use and the behaviour of their family member is not upto the expectation because they have no source of earning as they remain fully dependent on them for their livelihood.⁸

➤ **Erik Erikson (1978)**, "The eminent life cycle theorist, formulated that during old age (65 years) the individual has to negotiate through the last of the eight stages to discover 'Integrity' versus despair' here, the conflict is between 'integrity', the sense of satisfaction one feels reflecting on life productively lived and 'despair' the sense that life has had little purpose or meaning. However the old age holds no contended backward look unless one has lived beyond 'narcissism' and into 'intimacy' and 'generativity'. Without 'generativity', according to him, the elderly have no sense of world order and, without world order, no conviction of the calming idea that one's life has come at a time and

8. Institute of Social Work, New Delhi, Survey (Report) Problems of Aged; 1977, P.124.

in a segment of history when a person developed exactly as one did. Without that conviction, the elderly have a fear of death, despair and disgust."⁹

➤ **Kart (1981)** writes, "Available data in the United States define the elderly as those 65 years of age and over. Some gerontologists distinguish between the Young old (55 to 74) and old - old (75 +)."¹⁰

➤ **Rao, Venkoba (1981)** "It has been found that 3/4th of India's geriatric population is 'young old' (60-70) and the rest 'old old' (70+). An analysis of the type of family indicated that 52% came from extended family, 38% from joint family while 10% were from nuclear family. 12% suffered social isolation and a positive accepting attitude of spouses was found in 84% neutral attitude in 10% and rejecting attitude in 6%. Physical handicaps and illness were encountered in 54% and they included impaired hearing, vision, hypertension, diabetes mellitus, pseudobulbar palsy, Parkinsonism, ischemic heart disease. 46% were however free from physical illness. Dementia was predominantly seen in those over 75 years of age while affective illness was common in the 60s."¹¹

➤ **Prof. Bhattacharya (In regard of Aged - 1982 : 34)** had written that now time have come when our government should frame the national policy to look after the elderly people (Senior Citizens) :-

(i) According to census of 1971, there were 34 lakhs male and 14 lakhs females above the age of 60+ who were having no means/source of earning and were left by the family and the society with no regard

9. Erikson E.S. (Ed.) Adulthood, Norton, New Delhi, 1978.

10. Kart C.S. The realities of ageing; Allyn & Bacon Inc, Boston, 1981

11. Rao, Venkoba A. Mental Health and Aging in India. Indian Journal of Psychiatry. 1981, 23, 11-20.

and care for their painful end.

(ii) In the following years many surveys were conducted by different institute and the findings were: (a) In the year 1977 survey was conducted by Delhi School of Social work, on the basis of its findings 49.3% of aged has no income of their own. (b) In the year 1982 according to survey conducted by Social Work Institute Madras 51.8 aged having no means of earning.

(iii) In the year 1975 survey conducted by Social Work Department of Lucknow University had stated out that 51.9% of aged were having no income of their own. (d) On the basis of survey conducted by Social Work Institute of Delhi in the year 1977, 50% of aged were having good health but they were not indulge in profit making work. so it is quite clear that there is need to frame different policies and programmes for the retired aged by which they can earn.¹²

➤ **DeSuza (1982)** in his study "On the life of the aged persons among the urban poor of Delhi, found that although changes have taken place in the family structure due to urbanization and migration, but the family is still a source of security to the aged persons. The sons consider it their duty to look after their aged parents."¹³

➤ **Social Welfare Department, Central Social Welfare Board , New Delhi (1982 : 99)** has organised two days seminar to discuss the problems of aged and their solution with voluntary organization and government efforts and from their discussion following recommendation were forwarded :-

12. Bhattacharya B.N.; In regard of aged; Social Welfare magazine, Central Social Welfare Board, New Delhi, August 1982, page -34.

13. Desuza A The social organisation of aging among the urban poor New Delhi Indian social Institute 1982

- A policy should be framed on the national level for the welfare of aged.
- Arrangement of hostels and rest houses in villages and cities for the aged.
- To realise the importance of aged in the society and family, there should a programme which can raise the public awareness.
- In the different programmes running by the Central Social Welfare Board and voluntary organisation etc. should make full use of services of aged.

The general view regarding to the following recommendation were that the government all alone cannot implement these policies because on the one side the problems were complicated and difficult; and on the other side there are some responsibility towards the aged. To established the adjustment between both of them Central Social Welfare Board, Delhi adopted to play the leading role in an impressive manner. All were in favour that Social Welfare Department plays an important role of motivator in societal change. It has been also accepted by the voluntary organisations that they are capable to generate public support and participation which will help in activation of developmental programmes.¹⁴

➤ **Weg (1983)**, writes that "Along with the changes in the biological compositions to a greater extent life style factors are also much more responsible for disorders and diseases in old age. For instance life style, sedentary low fiber, high fat or high salt diet, heavy

14. Aged: Role of Government efforts and Voluntary Organisation (Seminar), Social Welfare, Central Social Welfare Board, New Delhi, 1982.

smoking and alcoholism may lead to cerebrovascular accidents, stress, exposure to environmental carcinogens over a long period of time, nutritionas deficienciel and excesses. Radiation, food additives, smoking occupational carcinogens have possible correlation with the occurrence of cancer."¹⁵

- **Sussman (1985)**, Says that "When families provide support to the aged, there can be a high opportunity cost in terms of stressed and deprivation among other family members. Alternatively when hard choices must be made between children and older people, the middle generation usually gives priority to children (the future) rather than old people."¹⁶
- **Cain (1985)** "Observed a heavy dependence on sons from village level studies in Bangladesh and India . Nine out of ten elderly in the Bangladesh village and 8 out of ten in the Indian sample lived either with or adjacent to a son 15 years or older."¹⁷
- **Mahadevan (1986:497)**, says that "In the traditional society of India a women is old when her son gets married. The people are old in India when they reach the age of 60 years."¹⁸
- **Prasad (1987:33)** "Although in India it is regarded as obligatory on the part of the sons to take care of their aged persons, yet sons belonging to the lower economic class fail to fulfil this obligation and

15. Weg, R.B.(1983) "Nutrition and the LateY years" Lost Angeles Andrus: Gerontology Centre, University of Southern California Press.

16. Sussman M. ; The family life of old people In: R.H. Binstock and E Shanas (eds.), Handbook of aging and the Social Sciences, 2nd edition, Van Nostrand Reinhold New York, 1985.

17. Cain M. The fate of the elderly in South Asia ; Implications for Fertility, Center for policy studies, Working paper No. 116, The Population Council, New York, 1985.

18. Mahadevan, K. A System of Policy for Welfare of the Elderly Citizens. Ind. Jr. Soc. Work, 1986, XLVI(4):497-585.

55% of the total population of India is below poverty line.¹⁹

➤ **Chanana et.al (1987)** Table given below puts a brief lights on the rapid growth of 60+ population :²⁰

- Percentage, decadal, increase in the general population and the population aged 60+

TABLE NO. - 2 (1)

Years	General Population			Population Aged 60+		
	Rural	Urban	Total	Rural	Urban	Total
1951 -1961	20.54	26.33	21.64	22.66	26.28	23.25
1961 -1971	21.85	38.22	24.80	30.03	45.17	32.39
1971 -1981	19.67	46.39	25.00	25.93	50.75	29.97
1981 -1991	15.54	44.06	22.19	23.38	52.71	28.94
1991 -2000	-	-	170.29			273.89

➤ **Rao (1990)**, found that "More than half of his rural elderly sample was socially well integrated and almost one third had moderate degree of social integration, thus making 95% of the sample either well or moderately integrated. Subsequent to the psychosocial intervention, a significant rise in social integration was seen (98%)."²¹

➤ **National Sample Survey Organization (N.S.S.O., 42nd. round- 1991)**, "Although we have aged homes to care for those left

19. Prashad, R. Problems of aged in India : some reflections. In: Sharma M.L. and Dak T.M. (Eds.). Aging in India : Challenge for Society, Delhi : Ajanta Pub. pp. 33-42, 1987.

20. Chanana H.B. and Talwar, P.P. Aging in India: Its Socio- Economic and Health Implication; Asia- Pacific Population Journal, Vol.-2, No. 3, 1987

21. Rao A.V. ; Health care of rural aged. Indian Council of Medical Research, New Delhi, 1990.

alone, the percentage of citizens who opt for these facilities is not encouraging. In India, only 0.68 percent of those in the rural areas and 0.40 percent in the urban areas are living alone as an inmate of homes for aged persons, which is very negligible. On the other hand, 7.31 percent and 5.54 percent in the rural and urban areas respectively are living alone but not as an inmate of home for aged persons."²²

- **United Nations (1992)**, "Only in the seventh five year plan (1985 - 86 to 1989 - 90) the Ministry of Social Welfare constituted, under the working group on Social Welfare, a separate sub-group on the welfare of the aged which recommended a comprehensive approach to the problems of the elderly, framing of a national policy, the extension of services for the aged in different sectors of the plan, the promotion of and support to voluntary organisations and the utilisation of the aged in national development endeavours."²³
- **Strauss and others (1992)**, "Conducted a comparative study in several countries concluding that even though women live longer, they are more sickly and disabled than men throughout the life cycle."²⁴
- **Altenhilfe (1992)**, "A recently completed survey of 27,000 households conducted for the Federal Ministry for Family and Seniors in Germany reported that 78 percent of the family caregivers surveyed reported that their responsibilities in their care put their families under great stress."²⁵
- **J.P. Pachauri (1992)**, "In India ageing is coming up as the main problem which is a natural biomedical process, in which physical

22. National Sample Survey Organisation (N.S.S.O.) Sarvekshana, Vol. XV, Nos. 1 -2 , Issue No. : 49, 1991

23. United Nations, Population Ageing : Review of National Policies and Programmes in Asia and the Pacific, Asian Population Studies Series No. 109, New York, 1992.

24. Strauss, John et.al. (1992)'Gender and Life Cycle Differentials in the patterns and determinants of adult health', Santa Monica, Clif : Rand Corporation and Ministry of Health, Govt. of Jamaica.

25. Altengilfe Haf of family caregivers in Germany receive no social support" Ageing International 1992,20 (1)29

symptoms starts coming up in human; which is the last phase of human life cycle, which is called 'Ageing' this condition is a reality and is compulsory, which is the condition of incapability. In this person feels himself being neglected. In this way ageing is a humanian problem. For its solution humanian ponit of view should be adopted because this condition has different problems like physical,mental,psycho-social, family, economical and adjustment."²⁶

➤ ***World Development Report (1993, World Book)*** "Indicate that between the ages of 15 and 44 and after age 60, men generally have higher rates of premature deaths while women have higher rates of disability. Female disability is especially higher in Asia, and much of it is attributable to maternal causes, STD•s and importantly gender based discriminations."²⁷

➤ ***Manton et.al., (1993),*** "Frailty pertains to chronically dependent elderly with multiplicity of physical and/or cognitive problems affecting adversely their daily functioning. Frailty assumes importance owing to an assumption of the rise of older population - especially of the 'old old' with the concomitant increase of the number of the frail elderly. Additionally, the financial resources for the care of frail elders even in the most developed countries seem to have become stretched with the result that the alternative methods of caring are being considered. However recent data have not supported the increasing trend in the number of oldsters."²⁸

26. Pachauri, J.P. - Ageing : A Social Analysis, Social welfare magazine,central social welfare Board, New Delhi, edition-7, february 1992, page - 20-37.

27. World Bank, 1983, World Development Report 1993, Investigating in Health, New York : Oxford University Press.

28. Manpon, K.F., Corder, L.S. and Stallard, E. Estimates of Changes in Chronic Disability and Institutional incidence in the U.S. Eldely Population from the 1982, 1984 & 1989, National Long Term Care Survey. Journal of Gerontology : Social Science, 1993, 48,S153-S166.

➤ **Conway et.al. (1993)**, says, "Long term care of bedridden and connectively impaired elderly is a difficult task. Vast amount of literature is accumulating on the burden of care giver stress. Many women, at some point in their adult years find themselves providing care to an elderly relative."²⁹

➤ **Sodei (1993)** observed that "In Japan as well as other countries ,including the United States, elder care is traditionally the role of women. Nearly 90% of caregivers are women in their 40s and 50s (one third are over 60) and from one - fourth to one third of working caregivers quit their jobs. Many people, including women themselves, have long believed that it is a women•s fate to take care of parents or parents in law."³⁰

➤ **Kumar V. and Khetarpal, K. (1993)** in their study "Research and Training for Geriatrics in developing Countries' reveals, with an accelerated rate of population ageing, developing countries will be faced with unprecedented challenge of grappling with diverse problems of multitudes of elderly subjects. These challenges are emerging in the face of rapid cultural dynamics in such countries. One of the most important factors limiting elderly care remains high level of low socio - economic status. It is therefore important to evaluate physical impairment in relation to socio - economic levels of our people. While such evaluations can be based on well established procedures of geriatric assessment screening, the finding will be quite useful in planning the need based services, manpower trainning."³¹

29. Conway - Turner, K. and Karasik R. Adult daughter's anticipation of care and caregiving responsibilities. Journal of women and aging, 1993, 5 (2) : 99-114.

30. Sodei, Tradition impedes empowerment in Japan, Ageing International, 1993.21 (1) : 22-26

31. Kumar , V. and Khetarpal K., Research and training in gerontology in developing countries. BOLD Quarterly Journal of International Institute on Aging Malta, 1993

➤ **Sureender (1994)**, pointed out that "There is a prestige issue for those opting for aged homes. Still people are not comfortable enough enough to leave their native place / home town and come to the old age homes. They feel that their family name might be spoiled if their relatives come to know about their stay in these homes."³²

➤ **James (1994)** According to one estimate , "The number of elderly 60 years and above in 1993 was 47.9 million, and this number is likely to rise to 75.6 million in 2000 A.D. In terms of percentage, from 1960 to 1980, the population of the elderly rose from 5.6 to 6.3 percent and it is likely to reach 7.2 per cent in 2000 AD and 9.5 percent in 2020 AD. Kerala recorded the highest proportion of elderly in 1990 where as West Bengal recorded the lowest proportion. By 2020, the percentage of aged in Kerala will rise to 15, with Tamilnadu trailing behind it at 13.65 per cent. In absolute terms however, Uttar Pradesh has eight million elderly which is the highest among the States. This is followed by Andhra Pradesh and Tamilnadu with four million each and Kerala having 2.3 milion elderly. Further, four -fifth of the elderly live in rural areas. Although Kerala is regarded as a socially developed state in India, the social situation with regard to the elderly in this state is characterised by a decline in respect for the aged, parents' preference for stay with daughters, and discomfort felt by the young educated elite in the presence of the elderly. As many as 74 percent of the elderly did not report loneliness or uneasiness while staying away from their children, relatives or friends. It may also be noted in this connection that since 1960, there is an overall decline in the work participation rate of the elderly and in the states where the elderly are working, it is yet to be ascertained whether this was due to

32. Surender S.;Sons Support to their parents: does it still continue ? Ageing & Society ,Vol. IV, No.1&2, Calcutta Metropolitan Institute of Gerontology, Calcutta, 1994.

compulsion, or one's own accord. In India, the average life span is 64 years and life expectancy of women exceeds that of men. whereas among the elderly women, 64.3 per cent were widows in 1981, the percentage of widowers was only 19.4. Again, in the higher age group of 70 years and above, this percentage for widows showed an upward trend. Further, old age dependency ratio is likely to double by 2025 AD. Three-fourth of the responders in a study regarded children as their main support in old age."³³

➤ **Surendran (1994)** "Contrary to expectation, more elderly people continue to work in India. In the 1981 census, 70 percent of the rural and 50 percent of the urban men were reported to be working. A good number of them resorted to begging. The highest number of elderly male beggars was in Madhya Pradesh followed by West Bengal. The measures to counter the entire gamut of problems include constituting an extensive social security system for the aged in the unorganised sector and setting up more old-age homes with modern amenities. Fifty seven percent of the old age-homes are located in Kerala and Tamil Nadu."³⁴

➤ **Singh, S.D. (1995)** - "In India to think on the problem of old people can be divided into two groups - firstly, those old people who have retired from government and non government job, secondly, those who were throughout the life but never retire. In ageing retired people face more problems than other people. They get more worried and unsafe when there is no one to help them financially. They find themselves helpless due to childlessness, unmarried and discarded and weak,

33. James, K.S. Indian Elderly : Asset or Liability. Economic and Political Weekly, September 3, P.2335, 1994.

34. Surendran, P. K. Population Elderly increasing, The Times of India, New Delhi Saturday, June 25, 1994.

physically incapable and disease infected. Retired people have one main problem of how to utilize their lone time. For happy life continuity of life and interaction with community are must. That's why to maintain the activeness and usefulness of old people, society should try to gain profit from their talent, intelligence and knowledge.^{"35}

➤ **Prof. Silawat Sudha S. (1995)** According to him, "State of physical mental health and age are the factor which decide that the person is aged. In this state the person is seen less interested incapable, laziness, lack of concentration, adjustment, irritation and like to make order because physical and mental state such type of person are found to be self centered, sad, depressed, sensitive and care for their future that is why they are unable to adjust their life. Main problem of these people are related to the sources of their entertainment, housing, social adjustment, economic and to look after their capital."³⁶

➤ **Tulika Sen (1996:297)**, Summarizes in her study that "Minor differences were observed with regard to mental stress and their causes between the groups of Bengali women from rural, urban and metropolitan areas. In health status, Calcutta women were better off probably due to easier availability of treatment. It seems the environmental conditions have not affected the physical and mental conditions to any considerable degree when the economic condition remains the same. Whether the variation in economic status alters the health and mental conditions of the women or not, is to be investigated."³⁷

35. Singh, S.D.; Aged: General and Retired - A Sociological Analysis Public Co-operation" Research Magazine, Punjab University Chandigarh, 1995, page 7-10.

36. Silawat Sudha S., Problems of Ageing; 'Samajik Sahyog' Quarterly Research Magazine, Year - 4, Edition 14, Shri Krishan Research Institute Ujjain (M. P.), 1995, page -11

37. Tulika Sen (1996), A health and socio-economic profile of the aged Bengali women, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.297

➤ **Indira Jai Prakash (1996:292)**, Summarises that "Sixty women ranging in age from 65 to 102 years, were interviewed and information about their life history was recorded. The interviews covered various aspects of women's lives such as health status, economic condition, marriage and children, living arrangement and psychological well-being. Like most other elderly persons across the world, this sample presented a picture of widowhood, economic dependence and progressive decline in health with ageing. However, there were several interesting features that marked these women's coping with their own ageing and adapting to the changing circumstances."³⁸

➤ **Bhatia and I.S. Muhar (1996:66)**, in his study reveal the fact that, "Care for elderly persons is the need of the day because with the advancement of age, they undergo inevitable physical, biological, economical, intellectual and personality changes. They yearn to be in the company of their children and grandchildren, but they rarely get it and starts feeling stressed, rejected and lonely."³⁹

➤ **Mohanpuria , K.L. (1996:98)**, Observed that "It appears desirable that with a view to implement directive principles embodied in Article 41 of the constitution, more benefit statutory and administrative in the nature may be conferred for the welfare of elderly people. Better care be taken of self employed by educating them about the schemes for their welfare by N.G.O.s."⁴⁰

➤ **Hebibullah, C.M. (1996:101)**, reveals that "The aging

38. Indira Jai Prakash (1996), Coping with aging : Psychosocial situation of older Indian women, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP.292-293

39. Bhatia, P. & Muhar, I.S. (1996), Psychosocial aspects of elderly persons, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.66

40. Mohanpuria, K.L. (1996), Constitutional and legal aspects for elderly welfare, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.98.

population is both a medical and sociological problem. First it makes a great demand on the health services of a community. In England, about one third of all hospital beds are occupied by those over 60 years. It is a huge economic burden on the community to meet the cost of retired pensioners and support vast medical and social services. A great strain is placed on younger generation to look after them. The modern philosophy is that the old must continue to take their share in the responsibilities and in the enjoyment of privileges for remaining active members of the community. The community must assist the aged to fight the triple evils of poverty, loneliness and ill health. Much care is bestowed upon old people in western societies by providing social welfare measures such as national assistance supplementary pensions, home services, home care services, meals on wheels service, old folk's home, sitter's up services and provision of services of health visitors.

the health promotional measures required by the old people are good housing, a balanced diet, reduction of physical and mental strain, some intellectual activity; an efficient geriatric services and welfare services such as access to clubs, hostel and houses. The specific preventive measures are avoidance of injuries, careful dieting and reduction of obesity, periodic examinations for early diagnoses and its treatment.⁴¹

➤ **Shankardass M. K. et.al. (1996:197)** in their paper namely, "A Sociological analysis of support networks in old age in India, indicated that the different type of support network visit. These different kinds of networks are related to different types of help seeking behaviour. The existence of support networks is dependent on four factors. The factors are (1) the availability of local family, (2) the specific family relationships available, (3) the closeness of ties with local family,

41. Hebibullah, C.M. (1996), Health care in the elderly, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.101.

and finally, based on the above mentioned three factors, (4) the pattern of interaction which the elderly develop with non-kin members."⁴²

➤ **Chadha, N. K. et.al. (1996:204)** in their joint paper namely, Intergenerational gap and psychosocial Health concluded that, "The ageing population will soon spread beyond the industrialized world. In the new globe, we will have to break new ground, for there is no precedent for what is to come. The early years of the 21st century will bring vastly increased numbers of older people. This generation of elders will change the basic character of human populations. They will put old age on the map. And, we all, as individuals have a crucial role to play - "Add life to the years that have been added to life by assuring all older person. independence, participation, care, self fulfillment and dignity."⁴³

➤ **Catalin P. (1996:59).** In his study namely "A demographic - Economic study concerning life condition of elderly persons summarised that the increase of demographic aging process in our country has a series of socio - economic consequences, and the formulation of a policy in favour of elderly population should be based on adequate information about their living conditions and need of Socio-economic service. The analysis of possibilities to continue the activity after the age of retirement revealed that only 13.8% of the elderly in the sample were still working on the following conditions; 5.2% working fewer hours/day, 2.3% by changing their profession and 6.3% with the same condition. For those who retired on reaching the age

42. Shankardass, M. K. & Kumar,V. (1996), A Sociological Analysis of Support Networks in Old Age in India, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.197.

43. Chadha, N. K. & Singh, S. (1996), Intergenerational gap and psychosocial health, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.204.

limit, reasons for not pursuing activity were; desire to remain retired, inability due to health conditions and non availability of part time work.⁴⁴

➤ **Sharma, S.D. et.al. (1996:18)** Summarised that "The demographic picture of elderly in India andelves into reasons of demongraphic charges occurring in the last two or three decades. The scenario of Indian elderly is analysed in terms of demographics variables as population growth, life expectancy, sex ratio, marital growth, life expectancy, sex ratio, marital status, econimc status as well as psychosocial aspects of elderly. The health of Indian elderly has also been analysed. The paper also deals with understanding of ageing in the context of traditional life cycle approach in Indian culture and provides insight into the psychological aspects of ageing."⁴⁵

➤ **Jamuna D. et.al. (1996:305)** in their joint paper summarises "That elder widow are identified as a special concern group in view of thier increasing numbers and dependency. Elder women are doubly marginalised due to the combined effects of aging and widowhood. This study aims to examsins expirically the psycho-social aspects like problems of adjustment, self-concept, physical distress, psychological distress, intensity of different needs and observances of widowhood practicaes among elder widows. The study sample consisting of 600 widows and non-widows belonging to two different caste groups in chettor."⁴⁶

44. Catalin, P. (1996), A demographic-economic study concerning life conditions of elderly person, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.59.

45. Sharma, S. D. & Agarwal, S. (1996), Ageing : the Indian Perspective, printed by Balaji Printers, 8703/ 15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.18.

46. Jamuna, D., Ramamurti,P.V. and Sudharani, N. N. (1996), Psychosocial aspects of elder widows, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP.305-306.

➤ **Singh U.k. (1996:185)** The objective of the present study is to explore the problems of health and medical care being faced by the old aged persons. Connected with this, exploration regarding the family support and social health servies available to the old aged persons are also the major focus of the analysis. A sample of 100 old aged persons, retired from government jobs, residing in Varanasi city has been selected through stratified purposive sampling technique. The data have been collected through a structured interview schedule. It has been found that the old aged persons are facing various health problems in the form of disease, disability, debility, neglect, apathy and isolation. Their helpless situation demands utmost family care and social assistance which have been found lacking. The family is responsible to a very large extent for the inadequate health and medical care of the old aged persons. Selfishness, greed, lack of respect for the old aged persons and decline in the familial and kinship bonds in contemporary society are mainly responsible for the old aged persons. Adequate social help, social security measures and secondary institutions are required to support the old aged persons and to fill the gap which has been caused by the decadence of primary bonds and affectionate relationship which existed in the family and supported the old aged persons.⁴⁷

➤ **Gangrade (1996:170)** "For an Indian, his family and its direct and social networks, the caste and the sub-caste are the beginning and the end of his human universe. For the American, his family is strictly a sort of a nursery to prepare him for the future on his own. The Indian family therefore provides necessary coping

47. Singh, U. K. (1996), The health problems of aged persons and the declining family support system, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi. P.185.

mechanism to take care of aged in the family. The basic difference between the two orientations is that in India the centripetal tendency is channel within the same ideological frame work so that no matter into how many castes or groups the people are devided, the desired end results are similar and accommodating, whereas, the cetrifugal American tendency makes for a diversity of free associations of clubs with a variety of different objectives, which may have no reference to each other or may be mutually destructive. Social workers must strengthen family structure to deal with the problems of the old within the family structure rather than putting them into old -age-homes. Institutionalisation, is not an answer to the problem of the aged. In fact, relieving of some of the functions of the family and other traditional institutions will, atleast, not dehumanise welfare services. The increase in the elderly population should not be seen as a problem let alone a disaster, but a triumph of the human race. It should be looked upon as a progress to celebrate, to plan for , to prepare for but not to mourn or be sorrowful about one might say that this is the occasion for the world to ring bells and not to ring hands. There in need for strengthening family, Kinship and social network ties with respect to aging, keeping old people in their families and communities with respect to their care rather than pushing them onto old -age homes. Robert Browning has rightly observed: **Grow old along with me The best is yet to be.** To sum up, relationships between the members of the family can develop to the point where union arises through respect loving and being loved. Let me and by citing two quotations, one by Gandhi ji and other by an unknown person."We shell become useless if we lack respect for elders"⁴⁸

48. Gangrade, K. D. (1996), Family and care of aged in India, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.170

➤ **Anklesaria, P.S. et.al. (1996:30)** "India is experiencing a dramatic change in the population pattern with a phenomenal increase in the number of elderly people, 60 years and above which is further compounded by widespread industrialisation and urbanization. The study was carried out on 679 urban elderly subjects and their spouses from the middle income strata (395 males and 284 females) aged 48-92 years. The sociodemographic and clinical status of the elderly people were investigated. There was a predominance of women in the younger age groups. The educational status of women was lower than men with the majority being involved in household chores. A higher percentage of women were widowed and financially dependent on others. The subjects studied were apparently healthy as 62% did not complain of any symptom, whereas on clinical investigation, it was found that 64% were suffering from chronic disorders that required medication to restrict morbidity."⁴⁹

➤ **Wasir, H. S. (1996:75)** "With the eradication of many infectious diseases the human longevity now is being challenged by the occurrence of diseases due to faulty life styles like overeating, lack of physical exercise, excessive consumption of alcohol, smoking habit and exposure to stressful (hostile) environment. Diseases like coronary heart disease, hypertension and cancer which are creeping up prematurely at young ages are the result of deviations from healthy living habits. A significant fall of over 30% in deaths due to coronary heart disease and hypertension over the last three decades in the USA and some other countries is mainly (70%) due to the attention being paid to

49. Anklesaria, P.S., Pohujani, S. M., Ashar, V.J., Joshi, K. N. and Gupta, K.C. (1996), Demographic and Clinical Characteristics of the urban elderly people, printed by Balaji Printers, 8703/15, D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.30

inculcate healthy life styles at all ages specially starting in the youth and only minimally (30%) due to the advances in newer pharmaceuticals and invasive therapeutic intervention. It is by adapting the healthy life styles involving simple food habits, physically active life, avoiding smoking and excess alcohol consumption, incorporating more complex carbohydrates like roots, tubers, legumes and avoiding refined sugars and saturated fats in diet, and practice of mental relaxation techniques and with regular physical exercise done in moderation that one can hope to lead a disease free life and cross over to beyond the age of three scores plus ten to happily join the octogenarians club."⁵⁰

➤ **Kumar, S. Vijaya (1996:80)** "To sum up, at present in the rural society majority of the elderly are exploited, victimized and discriminated. This is the unfortunate reality existing in the rural India. Gradually our traditional cultures are withering under the onslaught of mass media. Ours is a developing nation and the state alone cannot ensure elderly people a full, secure and harmonious life; it is the family which is to hold full responsibility. As discussed earlier that majority of the aged are not in favour of institutionalization and prefer to live with childrens' family in which filial piety is gradually weakening, it is important to strengthen these values and the capacity of the families to cope with the problems of caring for the elderly. The family system has to be supported with suitable incentives in order for them to undertake responsibility of their aged with less financial and physical hardships. Further non-governmental organizations would have to come forward to deliver the health services to the elderly

50. Wasir,H.S. (1996), Life styles and longevity, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.75.

especially in rural areas."⁵¹

➤ **Yadav, S.L. et. al. (1996:150)** "The continued improvements in acute medical care and the remarkably increased longevity of humans during the past 30 years place the application of preventive rehabilitation concepts and techniques for the elderly into a position of great prominence and priority. The minimises the morbidity among aged which ultimately provides them more independence and restores optimal level of function."⁵²

➤ **Singh, R.R.(1996)** "With the growing nucleation of the Indian family, occupational mobility, increase in longevity and distorted pattern of development which favours urban and industrial centres at the cost of the countryside, the traditional pattern family based care is undergoing rapid change. The virtual absence of social or income security programme(s) for the elderly in the informal and unorganised sector is adding to the difficulties of the elderly at a time when the economy is passing through the phase of structural adjustment. The traditional care-givers therefore are increasingly finding themselves in need of respite care due to myriad pressures on them. It is in this context that the Draft Policy of the Government of India for the Welfare of the Aged has been examined and alternatives explored for a smooth social transition, which, in temporal terms, will be encapsulated into decades rather than centuries as was the case in the developed economies. The latter are presently faced with the situation of social distress inspite of their material welfare."⁵³

51. Kumar S. Vijaya (1996), Quality of life and social security of the rural elderly, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP.80-81.

52. Yadav, S.L. and Singh, K. K. (1996), Perspective problems and preventive rehabilitation measures in the care of elderly, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.150.

53. Singh, R.R. (1996), Family change, elder care needs and social policy, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP.176-177.

➤ **Singh C., et at. (1996:62)** Summarised in their study which was conducted in the rural area of Meerut. A total of 7704 persons were surveyed, out of which 464 (6%) were elderly (> 60 years of age). Among the elderly 219 (47.2%) were males and 245 (52.8 %) females. Majority, 318 (68.5 %) of the elderly were Hindu by religion . Two hundred fifty nine (55.8 %) aged persons were aged person were engaged in some productive work. Out of 376 aged person living in joint families, 207 (55.0%) were respected, 71 (18.9%) were indifferently treated and 98 (26.1 %) were being neglected by their family members. 71.7 % of the aged males and 32.7 % of the aged females were addicted to one or the other addicting agent. Approximately ten percent of the aged who were currently married were not staying with their spouses. The findings suggested that there are considerable social problems faced by the aged persons of rural area of Meerut, Uttar Pradesh.⁵⁴

➤ **Olteanu, T. et. al (1996:70)** in their study "Psycho-Social and biomedical factors in human longevity concluded that in 56.76% parents, longevity determines the longevity of their children and only first borne leads longer life. They also found that a satisfactory familial climate, high cultural needs, self education during life, work and professional satisfaction, involvement in activity, balanced reaction to major stress during life and absense of neuroticism were important factors."⁵⁵

➤ **Bambawale, U. (1996:301)** "The aged have attracted a lot of attention through the media specially in the recently concluded Year

54. Singh, C., Kant, S., Kapil, U. and Kumar, A. (1996), Socio-economic status of the aged in rural Meerut, Uttar Pradesh, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.62.

55. Olteanu, T., State, D., Bodor-V.N. (1996), Psycho-Social and Biomedical factors in human longevity, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.70.

of the family when we could further emphasize the positive role that the aged have within the family as well as out of it. Today, however a stage has come when we require to concentrate on many of their problems including their abuse. This abuse may be respect either covert or overt but all the same it harms these already marginalized people. One can, on certain occasion encounter the total attitude of disregard, disrespect and lack of discipline that may at times be quite obvious from the younger generation. This is an example of gloss over, hideous truth or rather hypocrisy in a country which is supposed to revere the aged.⁵⁶

➤ **Reddy P.J. (1996 : 193)** "The observations in preceding paragraphs indicate greater prevalence of relatives among the daughter - in - laws (D(s) IL) of elderly in unorganised sector which is a reflection of their desire for the prosperity of the family and welfare of the elderly hoping better co-operation and interpersonal adjustment from them. This is proved to be somewhat true as neglect of elderly females was significantly greater by D(s) IL who were non-relatives than relatives put together. However, sub-classification of relatives revealed nearly every second crosscousin (both own nice and husband's niece) neglecting female elderly. The life of the widowed elderly who is deserted is more pathetic when compared to currently married elderly counterpart who has the companionship of spouse. One fifth of the widowed elderly were left to their own fate and another 7 per cent were residing with their married daughter , on desertion by sons. An equal number of currently married female elderly were, on desertion by their married sons, residing independently with their spouses. Of all the

56. Bambawale, U. (1996), Abuse of the aged, Uttar Pradesh, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP.301-302.

D(s)IL, neglect of female elderly was the least in respect of grand daughters on account of harmonious interpersonal interaction between them. Being grand daughter, much concern is shown for grand mother who is also mother-in-law which is evident from the quantum of food served and expressed feelings in giving food to them. Of the elderly females having daughters as D(s) IL, all of them except one were served adequate food affectionately, irrespective of the economic status of the elderly. In contrast, one-half each of the elderly of low economic status having non-relatives and distant relatives as D(s) IL perceived their D(s) IL as feeling inevitable about giving food to them while it was 22 per cent in respect of cross-cousins. Although cross-cousins are also having close blood relationship with female elderly, they were in no way better than distantly related D(s) IL in taking care of the elderly. A large number of elderly for households of poor economic status having D(s) IL other than grand daughters stated in unequivocal terms that they would be cared from as long as they help during inactive life. Some of them pointed that holding property would satisfactory care from D(s)IL when incapable of doing work. Grand daughters are preferred over others as D(s)IL in unorganised sector because of non-availability of grand daughters, wide disparity in ages and other constraints.⁵⁷

➤ **Ramamurti , P. V. (1996:217)** "The inability and the helplessness that come with age are highly frustrating and have been found to be stressful. Stress in old age comes from many sources e.g. loss of status, retirement, reduced income, poor health, relocation, life crises, long-term disability, intergenerational conflict, person-

57. Reddy, P.J. and Usharani, D. (1996), Perception of old age support in selection daughter-in-law : A study of the unorganized sector , printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.193.

environment incongruence, losses and changes in the family front etc. A study of sources and extent of coping mechanisms used in meeting the stress of aging was carried out on a sample of elderly in the age group of 60 to 80 years. Results showed that perception of stress was an individualised phenomenon. Mostly, the successful copers had positive self-acceptance of aging changes and favourable found to play a key role both in the perception of stress and its management."⁵⁸

➤ **Reddy, L. K. (1996:233)** Summarised in his study that "Health practices among the elderly come from a proper psychological attitude to one's health. It is based on a commitment with the desire to maintain good health. Wide individual variations have been observed in this attitude. These differences depend upon several psychological factors. The present study is a probe into good health attitudes and factors associated with them. Health attitudes were measured by an inventory prepared for the purpose. The psychological factors like locus of control, knowledge of health and practices of health were assessed by standardized inventories. The sample consisted of 120 retired elderly men between 60-80 years. Results indicated that certain personality factors and knowledge of health significantly influence health attitude during old age."⁵⁹

➤ **Krishnakumari, K. et. al. (1996:34)** "The areas which are more prone to the aging process are those which experience a sudden and sharp decline in the birth rate. This means that the young population of the 0-14 age group will be decreasing in these areas

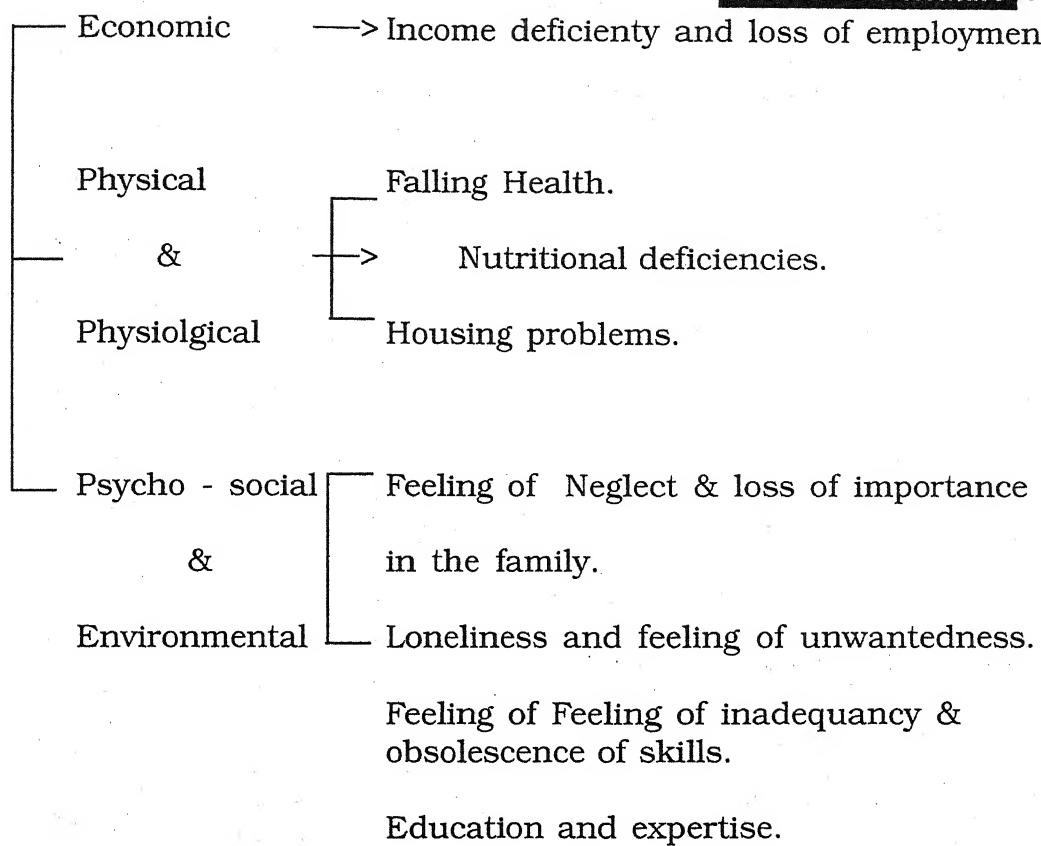
58. Ramamurthy, P.V. (1996), Aging as Stress : Strategies for coping, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.217.

59. Reddy, L.K. (1996), Health and attitude towards the health among elderly, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.PP233-234.

now compared to the earlier years. Usually a large amount of money has to be set apart for the care and upbringing of the children. An area which face a sudden decline of money (which is left over due to the lack of children in the lower age group) in the subsequent years. A large proportion of this amount may be spent for creating employment opportunities for the working age-group (15-59 population). This is essential because this population is the one which has to support the increasing older population. But in the long -run when the 0-14 population decreases to a very low level , it will result in a very high increase in the 60+ age groups and a slight decrease in the 15-59 population too. So at this juncture a large proportion of the left over amount can be spent for the welfare of the elderly. The sex-ratio reveals that, at ages, the proportion of women as well as their expectation of life at birth are high. In Kerala since the age at marriage of females is high and the difference in the age of spouses vary from 3 to 7 years, a women has to live as a widow for a long period of time. This means that (a) it may cause a burden for their children and (b) it presents mental agony for the women.⁶⁰

➤ **Prof. Goyal S.K. and Karole O.P. (1997)** has stated that "The age is an important factor that determines the dependency of a person. Though life expectancy has gone above 55 years in India, in rural areas, this is the age from where the aged feel neglected and uncared for. More than half of the senior citizens where the study was conducted,was above 60 years of age, and of this a majority were of females. The problems faced by the ageing be indicated as below:

60. Krishnakumari, K. & Sudev, P. B. (1996), Population aging in Kerala, printed by Balaji Printers, 8703/15,D.B. Gupta Road, Pahar Ganj, New Delhi - 110055, India. Ed. by Prof. Vinod Kumar, AIIMS, Delhi.P.34.



In view of the increase in the population of the aged and mounting expenditure on their welfare; it is all the more necessary that the aged involve themselves in voluntary services for the development of the nation. It would be in the interest of the aged themselves to involve them in a voluntary service mode to fit their time gainfully and arrest writing off of their skills, capacities and experience. To put in a nutshell there is a need to integrated the aged into their family and to make them wanted and accepted in the family and in the society as well.⁶¹

➤ **Prof. Sunil Goel (1997:40)** According to him "Ageing is not the disease more over (1) last phase of the human life cycle, (2) Natural biological process and (3) Necessary for every human being; in this dependencey and different problems errupts like physical, mental, family and economical."⁶²

61. Goyal S.K. & Karole O.P.; The Problems of Ageing; A Social Survey : "Samajik Sahyog" National Quarterly Research Journal, Published by Resear Management Syndicate. S.K.S. Sansthan Ujjain (M.P.) vol. 6 (21), 1997, page - 43

62. Goel Sunil; The Problems of the Tribal Aged; Need to Integrate them into the family; Samajik Sahyog, Quarterly Research Journal, Ujjain (M.P.) 1997, pp 40 - 45, Vol. 6 (21).

➤ **Surabhi Dabhare (1997:9)** has found in her 100 sample survey study :-

- (i) After retirement the women especially aged; are found unable to cope and establish adjustment with the family members because they believe to live according to her own principal; they doesn't want to live in the boundation of their son and daughter-in-law.
- (ii) They have no other source of income except their pension. 71.15 % of respondents survive their livelihood through pension.
- (iii) In order to remain free from household tension they quite often goes for pilgrimage and during summer vacation they often goes for visit.
- (iv) Most often aged likes to spend their pension on themselves as a result nearly 48% families has disputes on small matters and family tension raised.
- (v) Inspite of being in discipline the retired aged women like to keep the other family members in discipline, in which 90.5% were found unable.
- (vi) Retired women;take more interest in social work, in comparison to household works.
- (vii) 80% out of surveyed women had accepted that they spend most of their time in decoration and maintaining cleanliness in house and they easeout when they find that family members are not following them.

On the basis of these survey study conclusion can be drawn that educated retired women are unable to cope and adjust with their family members and the society because of their need to work according to their likes and dislikes which is not possible in this present time.⁶³

➤ **Ashrani, R.C. (1998:47)** summarises in his comparative study of rural and urban namely "Facts about the aged" that 45.8 percent aged in rural areas and 44.1 percent in urban areas are suffering from serious diseases, 5.34 percent aged in rural 5.56 in urban are physically incapable. He also reveals that 7.98 percent aged in rural areas and 5.94 percent in urban areas found lonely and the percentage of aged who are economically free; 24.9 and 28.94 percent.⁶⁴

➤ **World Health Organization (1998)** Reports on women, "Aging and health says that people with greater education consistently show less disability and better chances of recovery after illness. Among the cultural determinants, attitude towards older women, and attitude of older women towards themselves were having co-relation with health in aging process."⁶⁵

➤ **Rajuri Seema (1998:7)** has written after surveying health problems of the sample of 50 aged women belonging to Scheduled Caste and has found following-

(a) observed that fully percentage of aged women belonging to the schedule caste are uneducated so that they found themselves less interested regarding their health and way they are kept.

63. Surabhi Dabhare; Educated Retired Women : A Study ; Social Science Department , Annual Magazine, published by Aurangabad University, Aurangabad, 1997, page.- 9

64. Ashrani, R.C., "Facts about the aged", monthly news letter of Vigyan Prasar 'Dreams' published by Institutional Area, New Delhi, Dec. - 1998, P.47.

65. W.H.O., 1998 "Women, Aging and Health", Geneva : W.H.O.

(b) 90.5% of surveyed women were suffering from various diseases as the age was progressing (Tuberculosis, Asthma, Sightweakness, Paralysis, Diabetes, Joint pain)

(c) After suffering from illness they doesn't take precaution.

(d) 48% of them were found very careless regarding their health and are of eating whatever they like.

(e) She says most of the aged women are found saying that "they have seen, whole on the world and now they want to go close to God." On other they doesn't want to live more painful life.⁶⁶

➤ **Michel, Olivier (1999:20)** According to him specific needs for health care of older persons are not always taken into consideration due to age and handicaps. To avoid this government must target certain measures:

- Access of health care without discrimination of age;
- Access of information promoting a health education, aimed towards prevention;
- Access to proper food, adapted environment, avoidance of water of air pollution, related diseases.⁶⁷

➤ **Rani Vandana (1999:67)** She found on the basis of her study of 50-50 sample of rural-urban people:-

(i) Difference in the structure of family of aged in the rural and urban is quite clear.

66. Rajuri, Seema "Health Problems of aged - A study; Published Research - Thesis; Deemed University, Dayal Bagh; Dayal Bagh University Publication, Agra (U.P.), 1998, PP.138-139.

67. Michel Olivier (1999) : 'The Rights of Older Persons: Some medical aspects; 9 (3) pp. 20-23

(ii) In comparison to urban and rural aged are asked to make the decision on some important matters and weigh different respect. She says that nearly in 48 percent families of the rural areas, family members ask the aged in their family to make the decisions on the matter related to their family and like to discuss on the various matters before making any decision in comparison to the urban areas.

(iii) It has been found in 40% of the traditional Indian joint family system that the authority is been centralized to the aged people of the family but the change in authorily has been noticed regarding to the materialistic and self interest issue.

(iv) The study shows that the authority is being transferred in the family from the aged to the younger ones because of being the sole earner. In some family where there is a female who earns livelihood makes the decision.

(v) Only 17.5% families follow the decision which are made by the aged/head of the family. On the other hand 82.5% families follows the interest of the other members of family.

(vi) In relation to the interaction between the aged and other family members it has been found out that due to their diminising earning power the family members changes the way of interaction with aged.

(vii) In between the study it was noticed through deep study of family activity attraction of aged towards their family members is 67.60% as previously in comparison to 32.40% of other family members towards the aged. It has been also found out the aged also takes less interest

in family activity.⁶⁸

➤ **Agrawal Damodar (1999:93)**, According to his statement, "It would be much better for the aged to spend their time by entertaining through television by viewing various multiple programmes and serials on it so that they will not feel lonely and have stress. The main problem in this age is related to their mental state, so they should remain busy in household work. The other old person who doesn't do so begins to think ignored and differently. So there should be practice to make realise them that they have an important role to play in family and it should realise to them, the family members should not blame the aged for their mistakes. The only way to solve the problems of aged is to give proper concern and respect."⁶⁹

➤ **Ishi Khosla (2000:347)** On an overall analysis, "It may be stated that nutritional deficits in the elderly may play a significant role in cognitive dysfunction. Specific vitamin and mineral deficiencies can not only lead to frank confusional and neurological symptoms, but sub-clinical malnutrition can act synergistically or accelerate the ageing process, specially in the nervous system. The hypothesis that vitamins and minerals can play a crucial role not only in preserving and maintaining health, but also in restoring it to diseased patients, requires further research.

By far the most exciting area in preventive health today in the west, concerns reducing dependency and promoting self care, delaying degenerative changes among elderly, who though are likely candidates

68. Rani Vandana; Family status of aged; "Radhakamal Mukherji Chintan Parampara" Research Magazine of Social Sciences, Social Science Development Institute, Chandpur, Bijnaur (U.P.) Year - 1, Ed. -1, Jan. - June; 1999, P.67.

69. Agarwal Damodar, Role of television in entertainment of aged, publish Research letter, National Research Discussion, Seminar edition, Adarsh Krishn Degree College Shikohabad, January 1998.

for chronic physical and emotional illness, are also candidates for good health. Old age may be incurable but we can do much to delay its progression and make it more endurable. Good nutritional therapy is the only true preventive medicine. Modern technological and medical advances have enabled persons to reach a late age. This has served to add years to one's life. In any case we have still far to go to add life to one's years.⁷⁰

➤ **Sabharwal, M.M. (2000:398)** highlighted on the situation of elderly in India.

- 90% of older persons are from the unorganized sector, with no social security at the age of 60.
- 40% of older persons live below the poverty line, and another 33% just marginally over it
- 80% live in rural areas.
- 73% are illiterate, and can only be engaged in physical labour.
- 55% of women 60+ are widows, many of them with no support whatsoever.
- There were 150,000 centenarians in India in 1991 and will be nearly 200,000 in 2016.
- Dependence ratio 12.26, willl 14.12 by 2016.

On one hand there is the problem of rapidly growing number of aged persons, and on the other hand the economic pressures and social

70. Ishi Khosla (2000) Nutrition and Cognition in the elderly, Published by Health Care Promotion Trust (Regd.) National Institute of Primary Health Care, D-1017, New Friends Colony, New Delhi-110065, Ed. By Dr. P.C. Bhatla, P-347.

changes are weakening the filial ties and the joint family system, whereby the aged were now being treated with the same love and respect. From a position of authority and respect the aged today have become not only unwanted but at times intolerable.⁷¹

➤ **The Times of India Report (2005)** Presented in its report, "Close to 8.5 million of India's elderly stay all by themselves or with other old people. According to Census figures released recently, about 11% of India's 76.4 million people aged 60 years and above do not have a person below 60 living with them. This includes 4.9 million females (or 12.6% of elderly women) and 3.6 million males (9.5% of elderly men). And this is not counting those living in old-age homes.

Interestingly, this phenomenon is more pronounced in rural areas, where 11.9% of the aged have to fend for themselves, as compared to urban areas where the proportion is 8.6%. This seems to indicate that migration is at least as significant a cause for the loneliness of the old as the growing preference for nuclear families. Therefore, many of the old people living by themselves may be doing so as a compulsion rather than by choice.

Of the 8.5 million, over 3 million are aged individuals who live without any company at home. More than two-thirds of these, about 2.1 million, are aged women living alone, while there are about 9 lakh old men in a similar situation. Another 5.2 million live in homes where the only company they have is another elderly person. Among this lot, the gender distribution is more even with 2.6 million women to 2.5 million men, suggesting that most of them may be elderly couples.

71. Sabharwal, M.M. (2000) Rehabilitation of the older persons, Published by Health Care Promotion Trust (Regd.) National Institute of Primary Health Care, D-1017, New Friends Colony, New Delhi-110065, Ed. By Dr. P.C. Bhatla, P-398.

living on their own. The 2001 Census data shows that over 134 million of India's 193 million households have nobody above the age of 60. That leaves 58.3 million or 30.2% of all households with at least one elderly person as a member of the household. While 21.3% of all households have exactly one elderly, those reporting two comprised 8.4% of the total. This leaves a mere 0.5% of households with three or more elderly person each.

The share of elderly in rural areas (31.6%) is relatively higher than in urban areas (26.6%). Kerala (38.5%) and Punjab (35.4%) are two states with the highest share of households reporting at least one elderly member. Among states/UTs with more than 100,000 households, Chandigarh (16.4%), Arunachal Pradesh (18.6%) and Delhi (19.9%) reported the lowest share.⁷²



CHAPTER-III

SOCIO-DEMOGRAPHIC FEATURES OF RESPONDENTS

- Age
- Caste
- Educational
- Status
- Occupation
- Income
- Marital Status
- Type of Family
- Type of House
- Housing Facilities

SOCIO-DEMOGRAPHIC FEATURES OF RESPONDENTS

If we want to establish the relationship between smoking and lung cancer, we need data. If we want to test the efficacy of drug or vaccine, we need. If we want to know the status of elderly women, we need statistics.¹

Elderly women are in consideration and they are important part of the society so we must know what their status and problems are - their nature, their size and their distribution among the elderly women : how these problems vary from place to place, and how they change in time and by external conditions, economic and social. For any such assessment, certain basic measurements are necessary. These are called socio-economic and demographic data which is related to births, deaths, marriages, education, occupation and income that occur in a community. Accurately compiled and analysed the vital events serve as 'Yard stick' for measuring the status of population.

Status and problems of elderly women without demographic and social economic information has been compared to a ship without a compass.² To measure the status elderly women and to identify their problems, and for comparing that of one community with that of another, for comparing the present status with that of the past, for estimating the future needs of the community and to fix suitable target for achievements; because demographic processes, namely

1- Society for Social Medicines (1966). Evidence submitted to the Royal Commission on Medical Education, Brit. J. Pre. Soc. Med. 20, 158.

2- Brockington, C.E. (1958) World Health, 2nd Ed. Churchill, London.

fertility density, marriages, growth-rate and social mobility. These processes are continually at work within a population determining size, composition and distribution.^{3,4}

Socio-demographic features are vitally concerned with population, because status of the elderly women depends upon the dynamic relationship between the members of people, the space which they occupy and the skill that they have acquired in providing for their needs.

According to Shri K. S. Tilara (1990), A human being is a curious and worry being social person who survives in a society and interacts in between the nearest materialistic structure and environment with in the social structure which can not be separated from the social environment because that environment is a "thread" in which human being works like structure to form "living cloth" So it is clear that human being and environment are two sides of a coin.⁵ According to Lawania (1967 : 203) in total it is only the lively cloth and social background for human being, which is decided by the heredity and the environment.⁶ According to Saraswat (1993:157) Socio-cultural background is the social arrangement of that community which is indivisible and in which that social person resides.⁷ Prof. Ruter and Hart (1960 : 320) written in context of social arrangement in between

3- Govt. of India (1962) Report of the health survey and Planning Committee, Ministry of Health, New Delhi.

4- Govt. of India (1962) Report of the health survey and Planning Committee, Ministry of Health, New Delhi.

5. Tilara, K.S., Applied Sociology, Problems and Social Legislation, Publication Centre, Lucknow Uttar Pradesh, 1990.

6. Lawania, S.M., Indian Social Problems, Krishna Book Store Publication, Shikohabad, Uttar Pradesh, 1967 :203.

7. Saraswat Ramesh P., Indian Social System, Bhaduria Publication and Book Centre, Pvt. Limited, Etawah, U.P., 1993, P.-157.

social being and his living conditions lies, that, in society social background, is indivisible part of cultural environment, in which human being lives or have resided.⁸ According Mishra, P.K. (1997:137) Although human being is a social being that is why his desires and needs are endless and for the shake of his these needs and desires, his activities, success-failure, decides the background of his socio-economic and cultural life". It is also true that in the forrnation of every social being, his social status and role is decided by his background. That is why it is not only important instead it compulsory in a research of social science that the socio-economical and cultural aspects of samples should be studied deeply because in the formation of person's socio-cultural background many factors plays an important role.⁹ Prof. Agarwal (1981) have written that "Human being is not only a biological being but more beyond that and what he is more than that because of those his behaviour, his way of working, thinking and life -style is affected and we want to know fully about any person, we will not be able to know untill we are able to know his socio-economic and cultural background, in which he has grown up and the present society, community, family and environment in which he is living.¹⁰ Mainly the factors effects the person can be observed in two forms:-

- (i) Heredity (ii) Environment / Companion

Where a person's body (eyes, nose, structure, complexion, features etc.) is formed on the basis of his heredity, on the other hand his

8. Ruter M.R. and Hart P.R., An Introduction to Sociology, McGraw Hill Book Company, Koga Kusa, New York. 1960, P.320.

9. Mishra, P.K. Structure of Human Society, Vikas Publication, Jawahar Nagar, New Delhi. 1997-37.

10. Agarwal, Bharat, Indian Society : Past to present, Manmohan Das Book Centre, Private Limited, Bharatpur, Rajasthan, Revised Edition. 1998.

education, values, occupation, behaviour, habits etc. is accepted from the environment, that is why a person can't leave these factors.

According to Satyendra (1992) " It is important in the research of social science that the study of socio-cultural background and economic conditions of respondents play an important role".¹¹

The policy problems of uplifting this section is considerably more complex because urban socio-economic relationship by their nature are both varied and more complicated than traditional rural situations. The welfare of elderly women depend on numerous factors.

Most of the time policy decisions are taken on the basis of meagre and inadequate information about elderly women. No policy is going to yield gainful results unless we know those persons for whom the policy has been framed more closely and in more detail.

In the light of above facts researcher too in her study "Status and problems of elderly women" have studied various aspects such as religion, economic condition and housing condition etc. So that respondents of distinguish age, background, socio-cultural and economic status can be studied. In this chapter identified the sociological and demographic characteristics of respondents ,residing in urban area of Jhansi city. Tables given below put a brief light on respondent's distribution and selection :-

11. Satyendra, K. and Bhatnagar P. K., Research Design in Social Sciences, Social conditions and problems, Jagannath Publication, Pvt. Ltd., Darbhanga, Bihar Second Edition, 1992.

Table No- 3 (1)
Agewise distribution of respondents

Age (in Years)	Frequency	Percentage
60-65	108	36.00
65-70	70	23.34
70-75	55	18.33
75-80	51	17.00
Above 80	16	5.33
Total	300	100.00

Above table shows that 36% of the respondents were in age group of 60-65 years ,23.34% were in age group of 65-70 years, 18.33% were of 70-75 years of age, 17% belonged to the age group of 75-80 years, and rest 5.33% respondents were of above 80 years of age

Table No- 3 (2)
Castewise distribution of respondents

Caste	Frequency	Percentage
General Caste	50	16.33
Backward Caste	100	33.67
Schedule Caste	75	25.00
Muslims	75	25.00
Total	300	100.00

Above table highlights that 33.6% of the respondents belong to Backward Caste,followed by two groups constituting 25% i.e. Schedule Caste and Muslim Community and rest 16.33% respondents were from General Caste.

Educational Status in Central America

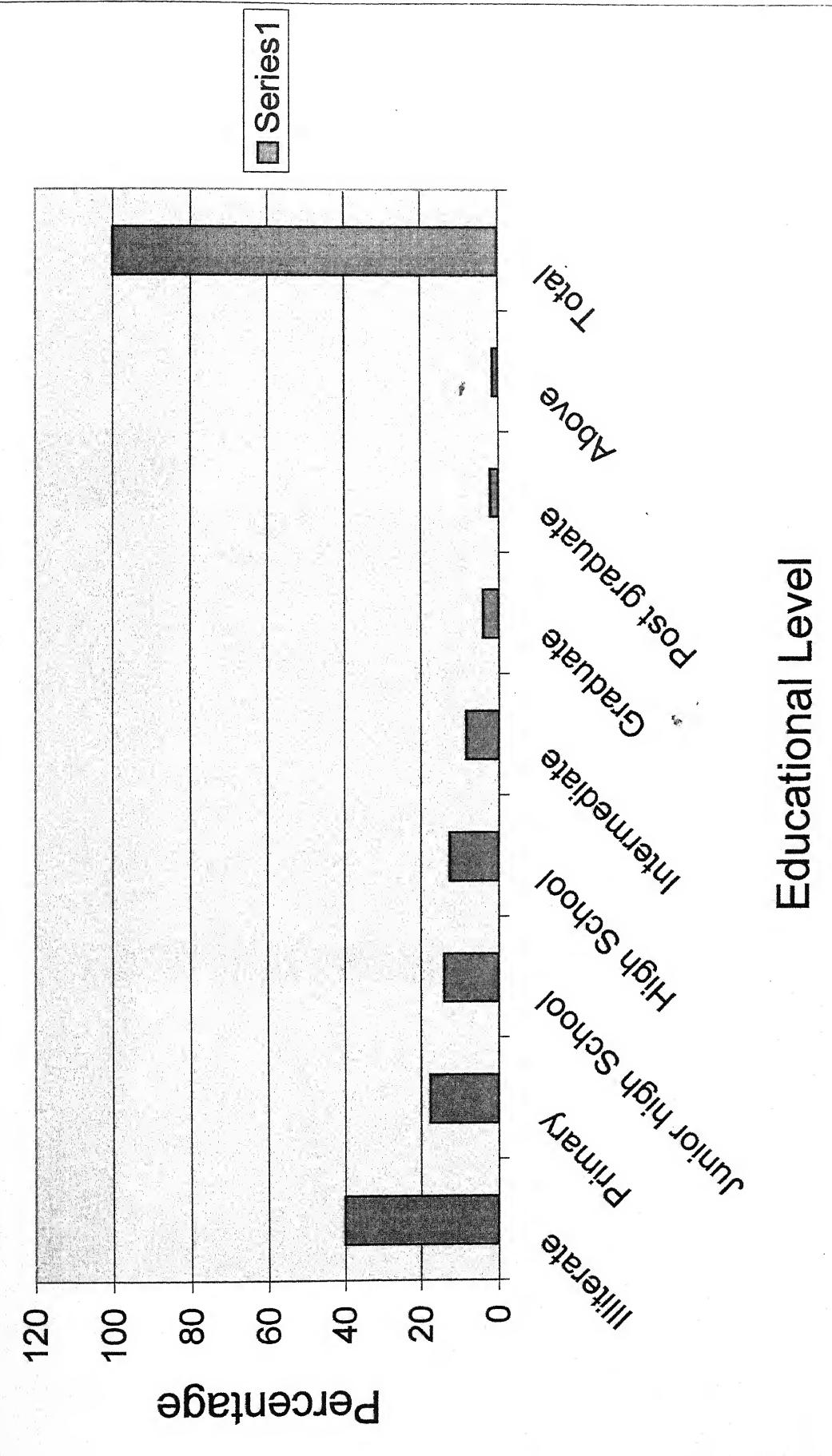


Table No- 3 (3)

Showing distribution of respondents by education status

Educational level	Frequency	Percentage
Illiterate	120	40.00
Primary	53	17.67
Junior high School	42	14.00
High School	38	12.67
Intermediate	25	8.33
Graduate	12	4.00
Post graduate	6	2.00
Above	4	1.33
Total	300	100.00

Above table reveals that out of total respondents 40% were illiterate whereas 17.67% had primary, 14% junior high school, 12% High school 12.67% and 8.33% Intermediate education while rest 4% respondent had done Graduation and 3.33% Post graduation and above.

If we compare the results of this study from the study of **Tulika Sen (1996)** of Bengali women, she founded that 8.66% were illiterate women, against 40% of this study, it was because of Calcutta city i.e. four times more.¹²

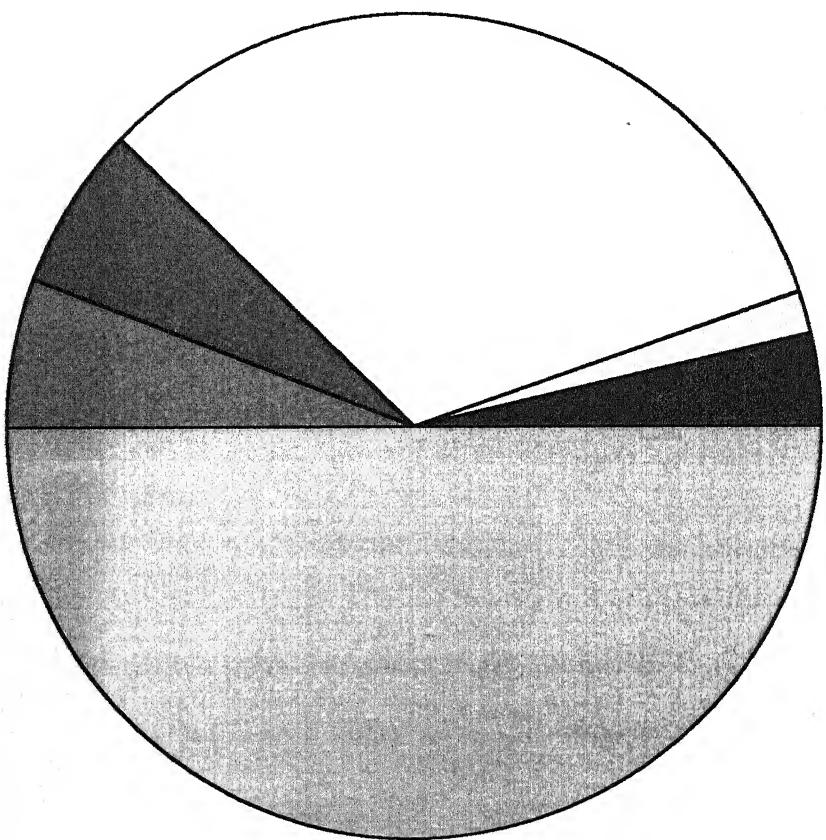
Table No- 3 (4)
Occupation Wise Distribution of respondents

Occupation	Frequency	Percentage
Agriculture	35	11.66
Labourer	39	13.00
Unemployed	195	65.00
Private Service	10	3.33
Retired	21	7.00
Total	300	100.00

12. Tulika Sen (1996 : 294), A Health and Socio-Economic Profile of the Aged Bengali women. Edit. & Pub. by Prof. Vinod Kumar, AIIMS, Printed by : Balalji Printers, 8703/15, D.B. Gupta Road, Pahar Ganj, New Delhi

Occupation

- Agriculture
- Labourer
- Unemployed
- Private Service
- Retired
- Total



Above table tells that 195 majority of respondents 65.00% were Unemployed which 13.00% were 13.00% were doing light labour, 11.67% were superwise agriculture work, 7.00% were retired and 3.33% respondents provided private services.

In the study of **Tulika Sen (1996)**; 12% urban women were in the earning category. Majority of women had no occupation. The working category included service, business, agriculture, animal husbandry and doctors. The results of her study were the more or less same from this study.¹³

Table No- 3 (5)
Showing monthly income of respondent's family

Monthly Income	Frequency	Percentage
Rs. 1000 or less	25	8.33
Rs. 1001- 1500	73	24.34
Rs. 1501- 2000	18	6.00
Rs. 2001- 2500	15	5.00
Rs. 2501- 3000	69	23.00
Rs. 3001- 3500	49	16.33
Rs. 3501- above	51	17.00
Total	300	100.00

From the above table we come to know 24.34% of the respondent's families were in Rs. 1001-1500 monthly income group, 23% were in Rs.2501-3000 income group,17% were having income more the Rs. 3501-3500 while rest 6% families were in income group of Rs. 1501-2000 and 5% having income Rs. 2500. per month. The average income of the respondent's family was Rs. 2475.

13. Tulika Sen (1996) as above.

Table No- 3 (6)
Showing marital status of respondents

Marital status	Frequency	Percentage
Unmarried	6	2.00
Married	129	43.00
Widow	143	47.67
Divorcee	13	4.33
Separated	9	3.00
Total	300	100.00

Above table shows that 143 majority of respondents 47.67% were widows followed by 43% were married, 4.33% respondents were divorcee and the remaining 2% were unmarried.

On the other hand **Usha Bambawale (1996)**, observed in her study, 56.25% married women followed by 38.30% widows, 1.04% divorcee, 0.25% separated and 4.16% elderly women were not married.¹⁴

Table No- 3 (7)
Showing type of family of respondents

Type of family	Frequency	Percentage
Nuclear	122	40.67
Joint	139	46.33
Extended	39	13.00
Total	300	100.00

Above table indicates that 46.33% respondents had Joint family while 40.67% had Nuclear family and extended families merely 13%.

14. Usha Bambawale (1996 : 298): Abuse of the Aged. Edit. & Pub. by Prof. Vinod Kumar, AIIMS, Printed by : Balalji Printers, 8703/15, D.B. Gupta Road, Pahar Ganj, New Delhi - 110055.

Marital Status of Respondents

- Unmarried
- Married
- Widow
- Divorcee
- Separated
- Total

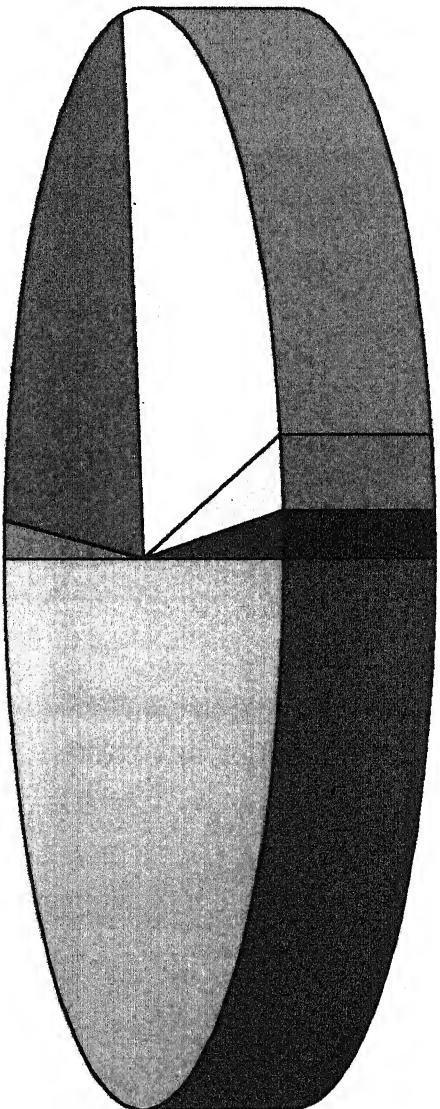


Table No- 3 (8)
Showng distribution of respondents by type of house

Type of house	Frequency	Percentage
Kaccha	57	19.00
Pacca	130	34.33
Mixed	113	37.67
Total	300	100.00

Above table shows that 43.33% respondents were lived in pacca house, 37.67% were in mixed house while rest 19% respondents were lived in kaccha house.

Table No. - 3 (9)
Showng housing facilities in respondents' houses.

Facilities	Yes	No	Total
	F (%)	F (%)	F (%)
Tap water	260 (86.67%)	40 (13.33%)	300 (100%)
Electricity	253 (34.33%)	47 (15.67%)	300 (100%)
Bathroom	270 (90%)	30 (10%)	300 (100%)
Kitchen	264 (88%)	36 (12%)	300 (100%)
Yard	256 (85.33%)	44 (14.67%)	300 (100%)

When did the houses of respondents were observed by the investigator and some enquiries were made regarding housing facilities in their houses, the majority of 86.67% respondents had Tap water supply followed by 84.33% electricity, 90.00% had bathroom facilities, 88.00% had kitchen and 85.33% had yard facilities in their houses.



CHAPTER-IV

- (i) Social Status of Elderly Women
- (ii) Social Problems of Elderly Women
- (iii) Economical Problems of Elderly Women
- (iv) Psychological Problems of Elderly Women
- (v) Physical Problems of Elderly Women

SOCIAL STATUS AND PROBLEMS OF ELDERLY WOMEN

There is no an individual, group, community and society which is free from any sorts of problems. Budha observed ; the life of man is full of sorrows. The primary cause of problem of an individual is his needs. Due to diversity of age, sex, economical status, environment and family culture problems are ever emerge in the life of individual. As needs are several in the same way, problems are also tremendous in their nature. In brief life is itself a problem solving process.Those those conditions or behaviour patterns which are objectionable by society is considered as social problems. Thus those adverse conditions that are not defined by the groups as reprehensible or undesirable are not known as social problems. For example, if gambling is not regarded as objectionable by the community, it is not considered a social problem. These social problems may be distinguished from physical and biological problems. Such as soil erosion, floods, tempesters, fires etc., in the former case an heart disease ,cancer, tuberculosis and other organic elements in the latter. Social problems seen deceptively easy to understand when compared to physical or biological problems.But when we try to change or control them they become resistant to change. For example, problem of elderly women is a very pressing and persistent social problem. It has been studied intensively and considerable knowledge has been accumulated about it. However, the rates of old age are higher today than they were sixty

years ago.

Ageing is treated a very complex and stage of problem,because several problems capture the men and an individual fails to adjust himself with them. There are many problems faced by the aged in India. The Hindu joint family which provided a sense of social security and status to the aged and worked as a social insurance system through reciprocal obligation of parents and children, has been weakened in recent decades. There are families where children are happy to send the parents and grandparents to the holy city of Banaras and Rameshwaram. The failism the unquestioned authority and regard for elderly which charcterised the Indian family, have been replaced by individualistic attitudes of youngsters. A large proportion of house holds is now headed by sons (and other of younger age) where the aged do not receive the same deference and care as in the olden days, and very often they are not consulted at all.

The increasing number of aged population posing newer problems health care, employment,financial constraints and diseases due to life styles-cancers, accidents, CVA'S, CAD'S, malnutrition depression etc. are having their toll. The basic problems related to old age are- multiple illness,multiple theraphy,introgenic diseases, loss of vision, hearing, mobility, social isolation, under employment psychological (mental stress,loneliness,depression and functional disability etc.

The problems and needs generally suffered by the aged today are generally health security, income security and emotional security. In advancing years, many age-related disabilities begin to appear. Mobility

suffers, hearing is impaired, loss of eyesight and memory occurs. The immune system declines, making aged people more vulnerable to infection.

National Sample Survey Organization (N.S.S.O., 1989) included various problems of ageing in its investigation. It describes them as social, economical, mental, physical and health related, environmental, disadjustment between new and old thinking, time consuming and recreation related problems included depreciation in authority interaction with family members, attachment with domestic activities their discardedness and fulfillment of basic needs etc.¹

On the other hand **Pachauri J.P. (1992:20)** reveals in his study that non-adjustment with family and society is the main problem from sociological point of view. Many old men feel mental tension owing to decrease in health status, retirement from job and economical hardship. Due to them the feelings of frustration, depression, negative attitude and excitement began to emerge on their mind. Which are hindrances in the adjustment with family and society.² **Staufer A. J. (1992:36)** writes on the basis of experiences of this study that :-

- (i) Ageing is a serious complex and universal problem of human life.
- (ii) Due to modern high speedly structural and functional change, a family is unable to do successful adjustment in assisting and securing orphans, widows and old men as it was capable of being done.³

Prof. Rani Vandana (1999:70) observes in her study that in present

1. National Sample Survey Organisation (N.S.S.O.) 1989, New Delhi.

2. Pachauri J.P., Ageing : A Social Analysis, Social Welfare Magazine, Central Social Welfare Board, New Delhi Edition Seven Feb. 1992, P.20.

3. Staufer A.J. (1992), 'Give them their due' Social Welfare Central Board (Monthly Magazine) New Delhi Vol. 29, No. 1-8, Oct.-Nov. 1992 P.20.

context the power and influence of family is forwarded and transferred into the hand of youngsters. The result is that the state of olds is converted into dependents.⁴

Chowdhary D.Pal (1997 :203) concluded ageing problems on the basis of his 50 old men survey that in old age individual is surrounded by tremendous problems by which he fails to adjust himself. He comprises the main problems- spend leisure time, problem of housing, property protection and care, new economical system, socio - economical adversities ,physical and heath problem, family adjustment and problems of power and influence etc.⁵

The emergence of new forces is however, a source of utter frustration and thereby for the maladjustment for large group of socially problematic older people in the society. It is because the adjustment of aging person depends upon the degree to which the personal and environmental circumstances offer opportunities or pose as threats.

Owing to above all these problem an effect of these problems can be observed in the large extent in the various dimention of their life for example :- loss of authority, respect and regard, intergenerational conflicts, partition of property, change of residence, neighbourhood,scarcity of finances, loss of occupation and social status,adverse physiological change like visual, hearing and cognitive impairment ,restrictions in activity, onset of degenerative organic and physical disorders. failure to keep pace with the transitional changes

4. Rani Vandana, Family Status of Aged 'Radha Kamal Mukherjee Chintan Prampara' Research Magzine of Social Sciences, Social Science Development Institute, Chandpur, Bijnor (U.P.) Year -1, Ed. -1 , Jan.-June, 1999 P. 70.

5. Chaudhary D. Pal (1997) P. -203.

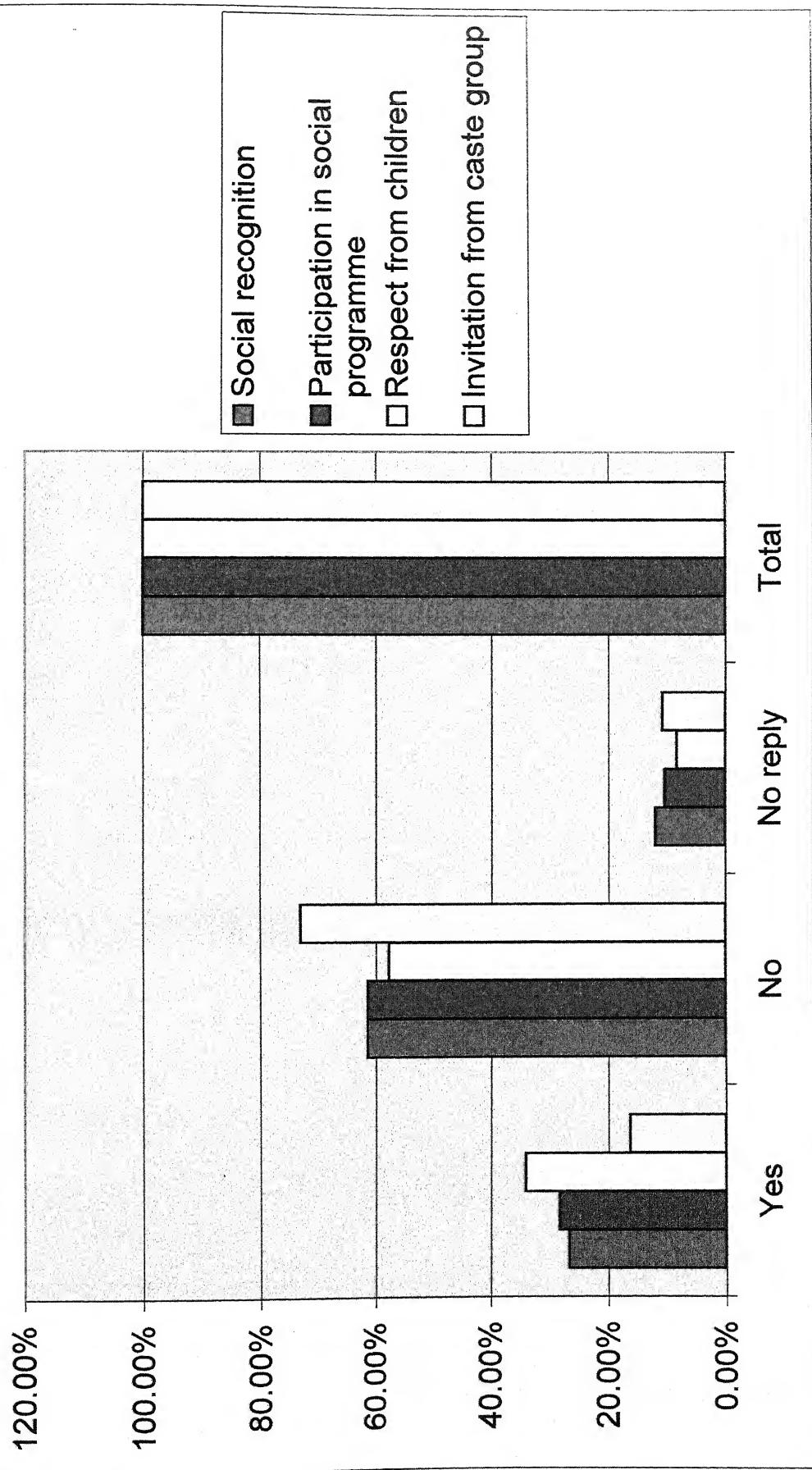
in society, loss of youthful vigour and freedom which is reinforced by prevailing social attitudes, poss of stablized emotional support due to death of friends, family members, feeling of loneliness, alienation, feeling of dependency ,death anxiety etc. So far as the status of eldely women are concerned; the results of this study are presented through following table :

TABLE- 4 (1)**Showing the social status of the respondents**

Social Status	Yes F (%)	No F (%)	No reply F (%)	Total F (%)
Social recognition	80 (26.67%)	184 (61.33%)	36 (12%)	300 (100%)
Participation in social programme	85 (28.33%)	184 (61.34%)	31 (10.33%)	300 (100%)
Respect from children	102 (34%)	173 (57.67%)	25 (8.33%)	300 (100%)
Invitation from caste group	49 (16.33%)	219 (73%)	32 (10.67%)	300 (100%)

Above table reveals the social status of the respondents, when the respondents were enquired about their social recognition 184 majority of the respondents 61.33% had not their social recognition in the society, When investigator asked them "why it is so" ? Those who were widows told that due to social stigma widows are not participated in any social as well as religious ceremonies and rest told that people

Social Status of Respondents



understood them useless. 26.67% had social recognition and rest 12% of the respondents not replied.

About participation in social programme 61.34% of the respondents said that they were not participated in social programmes and 28.33% said that they participated in social programmes and merely 10.33% were unable to give any response.

In context of getting respect from the children majority of 57.66% of the respondents said that they were not getting respect from their children as their children think that they are burden, while 34% of the respondents get respect from their children and rest 8.33% did not reply in this context.

In regard to getting invitation majority of women 73% did not get invitation on the basis of castism while 16.33% were in favour and remaining 10.67% were unable to give any response.

Table - 4 (2)

Showing association with friends

Association	Frequency	Percentage
Yes	53	17.67
No	85	28.33
Sometime	162	54.00
Total	300	100.00

From the above table it can be said 54% of women often enjoyed to the association of their friends while 17.67% said they enjoyed more over and the remaining 28.33% they did not enjoyed to the association with friends.

Table - 4 (3)**Showing membership of respondents in various organisation**

Membership status	Yes F (%)	No F (%)	No reply F (%)	Total F (%)
Member of social organisation	50 (16.67%)	224 (74.66%)	26 (8.67%)	300 (100%)
Member of cultural organisation	65 (21.66%)	217 (72.33%)	18 (6.00%)	300 (100%)
Member of religious organisataion	93 (31%)	187 (62.33%)	20 (6.66%)	300 (100%)

Above table tells that 74.66% of the respondent were not the member of any social orgnisation while only 16.67% were the members, 72.33% respondent were not the member of any cultural orgnisation and 62.33% were not recognized by any religious organisation.

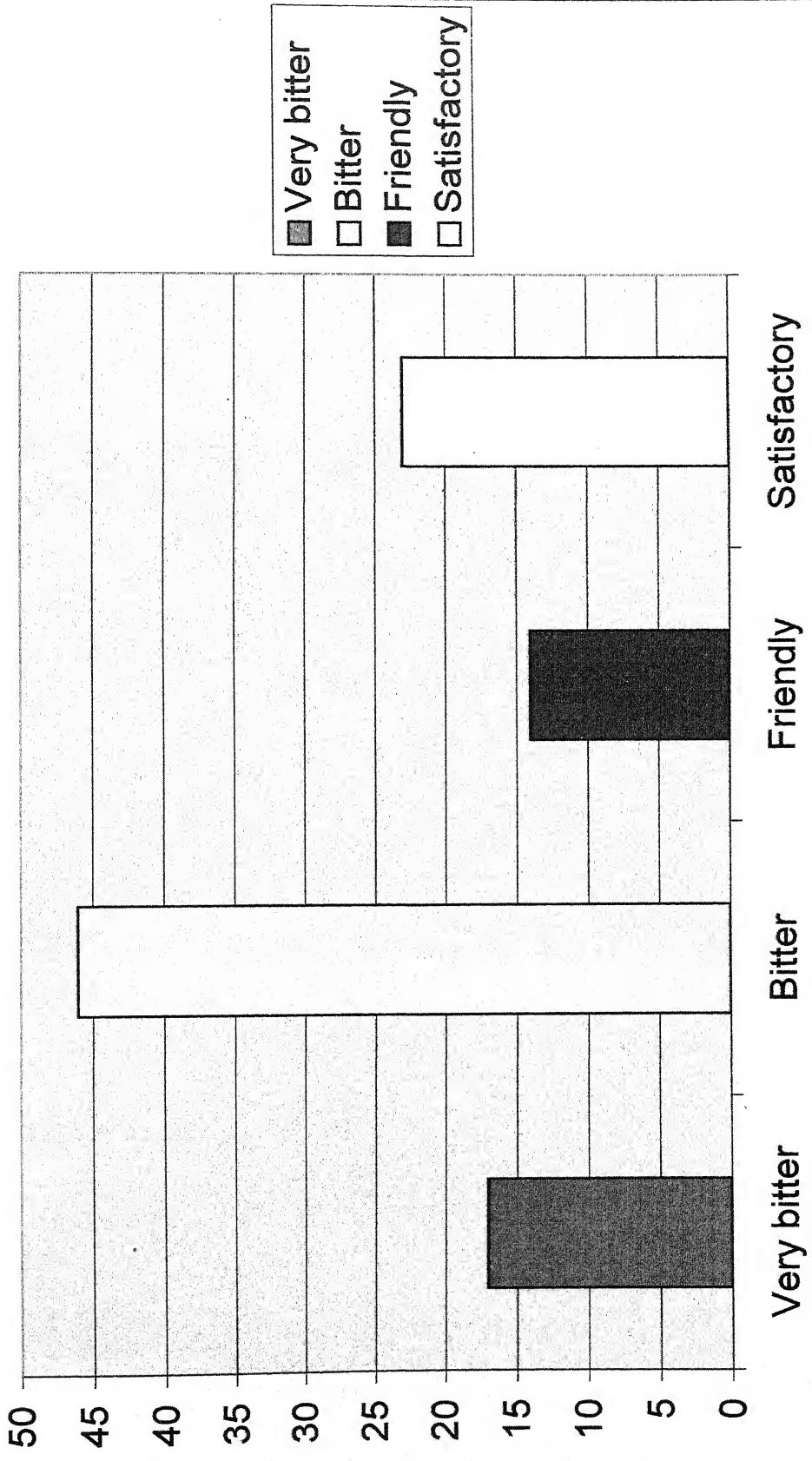
The table reveals the social status of elderly women and the majority of them had not recognised by the social, cultural and religious organisation.

Table - 4 (4)**Showing nature of interpersonal relations with family**

Nature of relation	Frequency	Percentage
Very bitter	51	17.00
Bitter	138	46.00
Friendly	42	14.00
Satisfactory	69	23.00

Above table shows nature of interpersonal relations between the respondents and family members .Care for elderly by family members

Interpersonal relation with family



depends largely on interpersonal interaction between them. The highest frequency 138 i.e. 46% of the respondents were having bitter relation with family members because most of them were belonging to lower economic strata, while 23% had satisfactory interpersonal relationship with family members. While 17% had very bitter relation and those were very poor and poor elderly. Only 14% of the respondents were having friendly interpersonal relations with family members.

Table 4 (5)**Showing acceptance of respondents by family members**

Acceptance by family	Frequency	Percentage
Loved /welcomed	96	32.00
Tolerated	135	45.00
Unwanted	40	13.33
No reply	29	9.67
Total	300	100.00

Acceptance by the family is a sensitive issue. From the above table it can be known that 45% of the respondents' were 'tolerated' by their families, 32% respondents said that they were accepted with 'love and welcome' by the family members and 13.33% of the respondents consider by the family as 'unwanted' members of family while rest 9.67% are unable to reply question.

Table - 4 (6)**Showing economic status of respondents**

Status	Frequency	Percentage
Earner	37	12.33
Dependant	218	72.67
Earner dependent	45	15.00
Total	300	100.00

Above table shows the economic status the respondents' and it shows that 218 majority of the respondent's 72.67% were dependant on their families while 15% were earner dependent and only 12.33% were earner.

Table - 4 (7)**Showing nature living arrangement of respondents**

Living arrangement	Frequency	Percentage
Alone	6	2.00
With only spouse	19	6.34
Spouse & children	52	17.33
With only children	169	56.33
With only grandchildren	31	10.33
With relatives	23	7.66
Total	300	100.00

As in Indian families where living with sons is the common practice, about 56.33% elderly women were living with their married or unmerried childrens, while the 17.33% were living with their spouse and children, 10.33% with only their grand children . Incidence of living with relatives were found 7.66% , living with only spouse shows

percentage of 6.34% and living alone was only 2% and some of them aged women had lost their spouses and some were living alone because they were unmarried.

Case Study - 1

A 69 years old respondent who was illiterate and unemployed said, "I am living separately with my husband not because we like it, but because of adjustmental problems and family telsions have forced us to withdraw ourselves from our married sons' family."

Case Study - 2

There was an another respondent who was 75 years old and High School passed labourer told to the researcher that, "I lost my husband nearly ten years back and afterwards I visited and stayed few months in each of the families of my sons and finally I decided to come back to here where I have small hut to live. I felt that I had to keep a separate establishment on accout of unhappy relations with my chiderns."

Table - 4 (8)

Showing individual freedom of respondents

Freedom	Yes	No	No reply	Total
	F (%)	F (%)	F (%)	F (%)
In decision making	101 (33.67%)	156 (52%)	43 (14.33%)	300 (100%)
In controlling the family	98 (32.67%)	163 (54%)	39 (13%)	300 (100%)
In fulfiling parsonal interests	85 (28.33%)	159 (53%)	56 (18.67%)	300 (100%)
In personal matters	88 (29.33%)	163 (54%)	49 (16.33%)	300 (100%)

From the above table; individual freedom of respondents can be known by knowing their status in decision making; in controlling over the family member; in fulfilling their personal interest and in personal matters. In decision making 156 respondents (52%) were not given opportunity to make the decision while 101 respondents (33.66%) were given opportunity to make the decision and the remaining 14.33% were having no reply in this regard. In the matter of controlling the family 54% had no right to control over their families, 32.67% had right, the remaining 13% respondents didn't answered. In the context of fulfilling personal interest 53% were having no right, while 28.33% were given opportunity and the remaining 18.67% were un replied. Lastly in personal matter 163 respondents (54%) had no freedom, 29.33% had freedom and 49 respondents (16.33%) didn't answered.

TABLE- 4 (9)

**Showing information related to properties in the names of
respondents**

Economic status	Yes F (%)	No F (%)	No reply F (%)	Total F (%)
House owner	61 (20.33%)	205 (68.33%)	34 (11.34%)	300 (100%)
Bank account	149 (49.67%)	112 (37.33%)	39 (13.%)	300 (100%)
Land	89 (29.67%)	188 (62.66%)	23 (7.67%)	300 (100%)

Above table shows that 205 respondents (68.33%) had not houses in their names while 20.33% respondents had house owners. In the context of Bank account 49.67% respondents had bank accounts in

their name and 37.33% had no bank account. So far as land ownership is concerned 62.66% had no land in their names and the 89 respondent (29.67%) had land in their names and the remaining 7.67% were unable to answer.

From above analysis of data the majority of respondents had their lower economic status in the families and society.

SOCIO ECONOMIC PROBLEMS

Ageing is everybody's problem as every one is bound to age and experience the impact .The problems in old age are special and unique. In society, gradually the problems of the aged related to health ,financial and socio-psychological aspects are becoming challenges to society and government.

Today elderly population is confronted with socio-economic deprivation and compromised health and this is likely to be more so in the developing regions of the world. "A number of social and economic problems are known to accompany old age. In Indian survey, 34% of the rural and 29% of the urban elderly were observed to be economically dependent and only 40% employed.⁶ Another survey showed that 33% were completely dependent and 10% were partially dependent economically.⁷

Burns;1954, Orback,1962 et.al. revealed that the problems of adjustment may have different critiria in socities which may be developed

6. National Sample Survey Organisation (N.S.S.O.), Govt. of India, 42nd round, July- 1986- June- 1987, No. 367, Revised report on Socio -economic profile of the aged person, 1989.

7. Kumar V., Soneja S., Khetarpal K.,Socio-economic profile of the urban elderly, Abst.ssubmitted at Slovak and Czech Gerontological Society Symposium on the Elderly, Primary Health Care, Bratislava, Slovakia, 1993.

or undeveloped, urban or rural, western or oriental and modern or traditional. The present technological society creates such an environment for the aged people that provides less opportunities for satisfaction of various needs and hence, less conducive to good adjustment in old age. One of the main causes of maladjustment of aged is economic problem. Diminished economic productivity of the aged, inflationary tends and changes in socio-economic values contribute to economic problems. Aging becomes more disturbing in a society whose culture provokes irreverence towards the aged and where the economic competition works to their disadvantages owing to the rapid advances in industrial technology.⁸

People in active services get an income, are kept busy for major part of the day ,have a standing in society and family because of their working status. But after retirement they have to face loss of the total income. The person who were not in job and working as labour/ farmer have to depend fully on their family. As their working capacity is deteriorated with the old age. The person who retires from the jobs have so much of extra time at their disposal that they do not know what to do it. They not only to survive with less or no income but also have to cope with a lowered status. They may not get respect either from the family or from the society. Added to it they have also to cope with their failing health. These changes take place rather more or less suddenly. At their young age when the aged are physically strong and

8. Burns, Robert K Economic aspects of aging and retirement. American Journal of Sociology, 1954, LIX (January) 384-390.

- Orbach, H.L. Aging and religion- Church attendance in Detroit Metropolitan Area, Geriatrics, 1962, 16:530-540

- Hauser, Phillip M. Change in the labour force participation of the older workers". American Journal of Sociology 1954, LIX, January :312-323

working were the useful members of the community or society. But the same person at sunset of their life when their working capacity deteriorated for retired from the jobs regarded as useless with nothing to do and quite a nuisance.

The aged who are not getting any income have to depend upon their children to fulfill their necessities. They have to face economic and psychological tensions in the family. As aged parents, they too have certain obligations like attending marriages, deaths of their kin, giving gifts to their visits and so on. Without any income or even with low income the aged parents cannot meet these social obligations and further they feel guilty to ask for financial help from their children. **Bhatia (1983)** reveals that aged people tend to have low income and little accumulated wealth, and as a result, many of them are in a poor position to maintain even the optimum standard of food, clothing, housing and social amenities. The problem of maintaining a reasonable standard of living of the aged and ensuring them the availability to basic physical amenities of life being given great importance in almost all the modern societies. Relatively with a much higher per capita income and greater physical amenities and better pension plans, the aged people in advanced countries are still considered to be in bad financial condition.

Financial crisis is one of the problems are as in old age. The economic resources has strong impact upon emotional and psychological state of an individual the living arrangement of aged their relationship with family and friends, and the nature and extent

of family interaction are all influenced by their income. Several studies have been conducted in relation to socio-economical problems of the aged. Some studies of them as follows :-

Dube (1955) in his study says that "Respect is shown to the older people in rituals only, but in everyday life we ignore them and parents dominate the family till their middle age but with approaching old age recede to the background."⁹

Mohanty M. (1996) observed in his study that 39.84% of the women were living with only their children followed by 37.11% with spouse and children, 11.34% were living with others, 8.59% with only spouse, while 2.34% alone and only 0.78% were living with spouse and others.¹⁰

Soneja S. et. al. (1996) observed in their study that majority of 87.9% elderly women were non-head of their and only 12.1% were occupying headship status in the family.¹¹

Majumdar (1985) revealed in his survey report that "When people age, they lose their grip over their children and lose the lable of the head of the family."¹²

On the other hand **Bose (1982)** observed that in the loss of status of elderly is due to economic depenedence, physical weakness and deomestic events.¹³

9. Dube, C. A Study of prevalence and biosocial variables in mental illness in rural and urban community of uttar pradesh, India. *Acta Psychiatr Scand*, 1955, 46: 327.

10. Motanty M. (1996) Bio-Social study on Aged people in Orissa.

11. Soneja S., Nagarkar K.M., Dey A.B., Khetarpal K. and Kumar Vinod (1996) Socio-economic status and its relationship to parameters of social morbidity among elderly patients seeking out patients medical care. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

12. Majundar, C. (1985) The end of the road. *Hindustan Sunday Magazine*, Oct. 6 1985.

13. Bose, A. B. Aspects or aging in India. *Monthly Public Opinion Survey*, 1982, 27: (2), 6-16

Prof . Kumar (1986-87) found in his study which was conducted in Chittoor (A.P.) that 48.59% majority of the elderly were dependent on their sons for their medical expenses, 25.65% on their daughters, 12.62% kin of the elderly beared their medical expenses while 8.36% get help from others and only 4.78% elderly depend upon their savings.¹⁴

Mohanty M. (1996) observed in his study the sources of elderly women's economic support in which he found that 51.56% elderly women get support from their son followed by 22.27% from pension, 14.06% of the elderly women's source was property, 11.33% deposit and only 0.78% get economic support from others.¹⁵

Anklesaria P. S. et. al. (1996) study revealed the financial status of elderly women which shows that majority or elderly women were dependent on others."¹⁶

On the other hand **Mohanty M. (1996)** observed in his study namely 'Bio-social study on aged people in Orissa' that economic condition of 67.66% rural elderly was worse compared to 29.25% among urban elderly 29.67% rural elderly lend middle economic life and it become almost double among urbanelderly".¹⁷

Soneja S. et. al (1996) revealed the dependency status of elderly women; they found that 67.6% of the elderly women were fully dependent followed by 27.6% independent and 4.80% elderly women were partially dependent.¹⁸

14. Prof. Kumar , Family life and Socio-Economic Problems of the Aged, 1986-1987, p-112.

15. Mohanty M. (1996) 'Bio-social study on aged people in Orissa' Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

16. Anklesaria P.S., Pohujani S. M., Ashar V. J., Joshi K. N. and Gupta K. C. (1996) Demographic & Clinical characteristits of urban elderly people. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

17. Mohanty M. (1996) As above.

18. Soneja S. et. al. (1996) As above.

In this study attempts are being made to identify socio-economical problems which affects life of elderly women. These problems are presented through following tables along with statistical analysis and interpretation.

Table - 4 (10)

Showing social problems of the respondents.

Social Problems	Yes	No	Sometimes	Total
	F (%)	F (%)	F (%)	F (%)
1. Free to associate with outsider	116 (38.67%)	64 (21.33%)	120 (40.00%)	300 (100%)
2. Respect given to your friends	54 (18%)	169 (56.33%)	77 (25.67%)	300 (100%)
3. Feeling isolated from society	126 (42%)	74 (24.67%)	100 (33.33%)	300 (100%)
4. Free out & in going	87 (29%)	64 (21.33%)	149 (49.67%)	300 (100%)
5. Headship status	40 (13.66%)	208 (69.32%)	52 (17.32%)	300 (100%)

The above table shows that 40% of the respondents could meet sometimes with outsiders, 38.67% were able to meet with the outsiders without any hindrance, while 21.33% of the respondents were restricted to associate with outsiders.

In regard to respect given to respondent's friends 56.33% family members of the respondents not respected the friends of elderly womens, while 25.67% respect sometimes and the remaining 18% family members

of respondents respected the friends of elderly women.

In relation to feeling of isolated from society and associated 126 majority of the respondents (42%) said that they were associated with society, while 33.33% of the respondents sometimes associated with the society and rest 24.67% said they didn't.

About free out and in going to their relatives 149 majority of the respondents 49.67% said that they were rarely allowed to visit their relatives ,while 29% respondent often visit to their relatives and rest 21.33% of the respondents visit never to their relatives.

When the respondents were enquired about their headship status in the family, the majority 208 (69.32%) of the respondents have lost their status of headship in the family while 17.32% were sometimes head of the family sometimes and 13.66% of the respondents occupied their headship status.

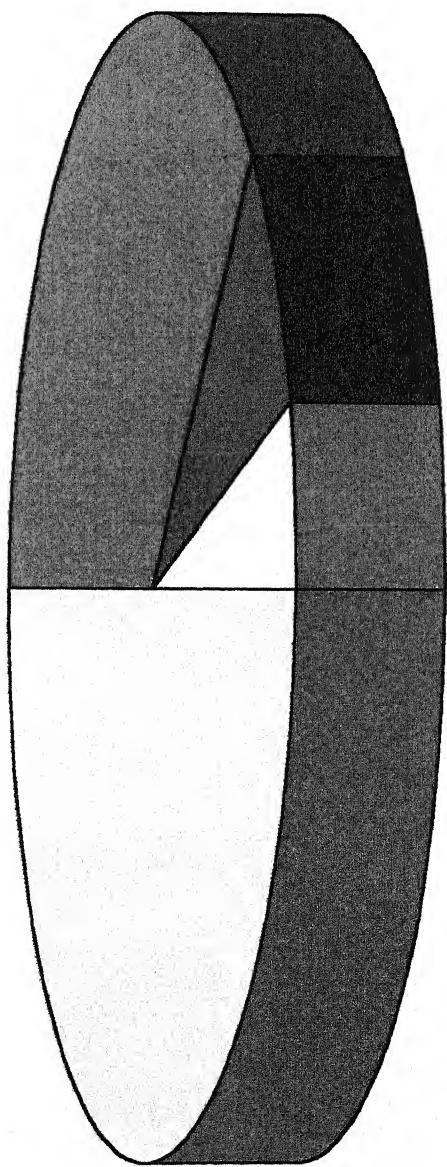
Table - 4 (11)
Showing dependency of the respondents' on their
family members

Dependency status	Frequency	Percentage
Fully dependent	218	72.67
Partially dependent	50	16.66
Independent	32	10.67
Total	300	100.00

Above table indicates towards the dependency of the respondents' on their family members, the 72.67% respondents were fully dependent on their family for everything, 16.66% were partially dependent and

Respondent's dependency on Family Members

- Fully dependent
- Partially dependent
- Independent
- Total



only 10.67% of the respondents were independent.

On the other hand Soneja S., et.al. (1996) found in their study that 67.6% women were completely dependent on their family followed 27.6% independent and only 4.80% women were partially dependent. It is because this study was conducted in Delhi which is prosterous in the country. People are well educated and had best standard of living and the women are also working and well settled.

Table - 4 (12)**Showing the way by which the respondents get pocket money**

Response	Frequency	Percentage
By demanding	165	55.00
Automatically	66	22.00
Not provided	42	14.00
No need	27	9.00
Total	300	100.00

The above table reveals that 55% of the respondents were getting money by demanding from their family members, 22% get money automatically while 14% said that their family members not provided them money and the remaining 9% had no requirement of pocket money.

Case Study - 3

A 72 years old respondent and she had done graduation and in passed days she was in govt. service but today her condition was very worst, today she gets pension but after that nothing is in her hands, she is fully dependent on her family. She told to the researcher that,

"One of the respondent who was 65 years old told of the I feel shy, sometimes to ask money from my son and sometimes I feel happy because my son questions me about the details of my expenditure. I am helpless and I am not able to fulfil even my daily needs. If I ask money they starts murmuring and I dislike to exchange words with my sons, If I do this they will eliminate me from the family definitely."

Table - 4 (13)

Showing source of medical expenses of respondents

Sources	Frequency	Percentage
By son	156	52.00
By daughter	38	12.67
Kin	77	25.66
Friends	15	5.00
Savings	14	4.67
Total	300	100.00

Above table tells that an overwhelming majority about 52% of the respondents received financial help for their medical treatment from their sons and about 25.66% received help from kin and those who received financial help from kin, were either not having good relations with their sons/daughters, or not having children, or having children who were economically poor to extend financial help to them. Other than those 12.66% of respondents received help from their daughters and 5% were dependent upon their friends from financial help for medical treatment and very less 4.67% of the respondents were capable of meeting their medical expenses out of their little savings.

Case Study-4

A 74 years old respondent whose qualification was intermediate and belonged to a well reputed family told to the researcher, "Both me and my husband fell sick for long time and my four sons extended their full financial help and personal attention. Afterwards, I recovered but unfortunately my husband is still bedridden, and slowly my sons retreated their financial help. They have, of course, their own families and expenses, and in such conditions we can't expect prolonged help from them and in the age to 74, I am working to get money for the treatment of my husband but I am not able to do work".

Table - 4 (14)**Showing sources of respondents daily economic needs**

Sources	Frequency	Percentage
Business	37	12.33
Pension	22	7.33
Property	45	15.00
By son	158	52.67
By daughter	38	12.67
Total	300	100.00

Above table shows the sources of respondent's daily economic needs. 52.67% of the respondents sources was their son who fulfil their needs while 12.15% of the respondent's source was property, 12.67% of the respondents source was their daughters and 12.33% fulfil their needs from their business and the remaining 7.33% respondents get pension to fulfil their daily economic needs.

PSYCHOLOGICAL PROBLEMS

Three aspects of human ageing have been differentiated by investigators. The biological age is an estimate of the individual's present position with respect of his potential life span, psychological age refers to the adaptive capacities of individuals, and social age refers to the roles and social habits of an individual with respect to other members of society. Many changes occurs due to aging which can be physical, psychological, cognitive social or often a combination of these four major areas. Aging affects almost all processes of life and depression can be a consequence of any one or multiple of these changes. An equally important causality is a feeling of loss of family jointedness. Even in homes where the aged are living with their own children, the seniors experience that emotional bonds are weakening.¹⁹

It is commonly believed that the elderly lead a rather gloomy existence characterised by social isolation, beset with health problems and suffer considerable emotional stress. In a similar vein, retirement is seen as leaving a vacuum which is impossible to replace.²⁰ Most of the time elderly persons living with their children find the presence and activities of their children and young grand children tension producing because they find it hard to adjust to the new changing environment. Nobody seems to listen to their sound advice, wise suggestions and counselling. Sometimes loneliness and rejection also cause tension.²¹

19. Bhogle S. and Reddy R.(1996) Depression and family jointedness among aged. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

20. Chadha N.K. and Singh S.(1996) Intergenerational gap and psychosocial health.Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

21. Bhatien P. and Muhas I.S. Psychosocial aspects of elderly persons Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

The psychological characteristics include abject and painful sadness, generalised withdrawal of interest, inhibition of activity, pervasive pessimism manifesting itself as diminished self esteem, gloomy evaluation of one's future and present situation, poor short term memory, slow reaction time, slow grasp and slow communication, they exhibited a fair degree of tolerance to frustration of life, measure of death anxiety showed low death anxiety. Some said "No body can escape death, let it come when it comes." In relation to psychological problems the reference of many psychologist given below :-

- **Chadha N. K. et. al. (1996)** revealed in their study that "Sleeplessness and forgetfulness were the main psychological problems, among the elderly in both sex."²²

Majumdar (1985), found while doing a survey of the elderly in Delhi that after retirement, everyone's attitude towards them changes and they feel lonely and perceive a void in their life.²³

Chadha N.K. (1996) observed in his study namely "Life satisfaction of aged: Psychological and social net-work analysis' that in old age male and female both feel loneliness, but females were somewhat more lonely than males."²⁴

Rao K. S. et. al (1996) revealed in their study the attitudes of elderly towards their life which showed that 60% of the majority of aged people were depressed, 30% indifferent and only 10% were happy in their life.²⁵

22. Chandha N. K. et. al. (1996) As above.

23. Majumdar, C. The end of the road. Hindustan Sunday magazine, Oct. 6, 1985

24. Chandha N. K. et. al. (1996) As above.

25. Rao K.S. (1996) The psycho-sociological problems of the disabled rural aged. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.

Greecy et. al. (1985) observed in their study that " Social fulfillment was the most important predictor of loneliness. The higher the social activity, the greater his or her sense of social fulfillment and this lowers the level of loneliness."²⁶

Here attempts are being made to study the psychological problems of elderly women, the results are presented through following tables:

Table - 4 (15)

Showing feeling of respondents about their life

Feeling	Frequency	Percentage
Worried	189	63.00
Happier	40	13.33
Normal	71	23.66
Total	300	100.00

When the respondents were enquired about their feelings of themselves the majority 186 respondents (63%) replied that they were worried in their life, 23.66% felt normal and 13.33% of the respondents told that they are happier in their life.

Rao K.S. et. al. (1996) found in their study that 60% of the elderly were having depressed attitude towards their life followed by 30% indifferent and only 10% elderly were happy in their life. In nutshell the only one common attitudes of elderly women about their lives was 'worried' in present and as well is Rao's study(The psycho-sociological problems of the disabled rural aged).

26. Greecy , R. E., Berg, W. E. and Wright (Jr) R. Loneliness among the elderly : A casual approach. J. Geronto., 1985 40:(4), 487-493

Table No. 4 (16)
Showing psycho problems among respondent

Problems	Yes	No	Sometime	Total
	F (%)	F (%)	F (%)	F (%)
Problem of sleep	138 46%	87 29%	75 25%	300 100%
Problem of Obstinacy	119 39.67%	94 31.33%	87 29%	300 100%
Feeling of irritation	153 51%	78 26%	69 23%	300 100%

Above table reveals that 138 majority of the respondents (46%) had the problem of sleeplessness, 29% respondents had not such problem, and the remaining 25% of the respondents sometime facing the problem of sleeplessness.

In context of problem of Obstinacy in behaviour of respondent that 39.67% of the respondents felt Obstinacy in their behaviour, 31.33% did not and rest 29% of the respondents sometimes felt problem of Obstinacy in their behaviour.

When the respondents were enquired about feeling of irritation 153 majority of the respondents (51%) felt irritation in their behaviour, while 26% respondents did not feel it and the remaining 23% respondents said they were sometimes feel irritation in their behaviour.

Table - 4 (17)

Showing various stages of Dementia among respondents

Dementia	Frequency	Percentage
Mild	51	17.00
Severe	149	49.67
Moderate	100	33.33
Total	300	100.00

Dementia is one of the serious problem among elderly women. Majority of 149 respondents (49.67%) were suffering from severe problem of Dementia while 33.33% respondents had moderate and rest 17% of the respondents facing mild Dementia.

Table - 4 (18)

Showing feelings of respondents about themselves in the family

Feelings	Yes	No	Sometime	Total
	F(%)	F(%)	F(%)	F(%)
Neglected	153 (51%)	39 (13%)	108 (36%)	300 (100%)
Decreasing importance	150 (50%)	46 (15.33%)	104 (34.67%)	300 (100%)
Loneliness	168 (56%)	37 (12.33%)	95 (31.67%)	300 (100%)
Insecurity	131 (43.67%)	52 (17.33%)	117 (39%)	300 (100%)

So far as the feelings of respondents about themselves in the family, 51% of the respondents were neglected, followed by 50% decreased importance is decreasing in the family. 56% respondents

felt loneliness, while 43.67% thought that they were insecure.

Table - 4 (19)

Showing causes of tension among respondents

Causes	Yes F(%)	No F(%)	Total F(%)
Marriage of children	61 (20.33%)	239 (79.67%)	300 (100%)
Tension between mother and daughter- in- law	207 (69%)	93 (31%)	300 (100%)
Declining status of family	127 (42.33%)	173 (57.67%)	300 (100%)
Unemployment of sons	117 (39%)	183 (61%)	300 (100%)
Insufficient House space	220 (73.33%)	80 (26.67%)	300 (100%)
Conflict between son and daughter- in- law	196 (65.33%)	104 (34.67%)	300 (100%)
Drug addiction of son	173 (57.67%)	127 (42.33%)	300 (100%)
Gambling by son	121 (40.33%)	179 (59.67%)	300 (100%)
Indiscipline of children	204 (68%)	96 (32%)	300 (100%)
Health problems	278 (92.67%)	22 (7.33%)	300 (100%)

When the respondents were enquired about the causes of tension; the majority of 207 (69%) replied that tension between mother and daughter - in - law followed by insufficient space of housing 73.33%, conflicts between son and daughter-in-law 65.33%, indiscipline of children 68% and health problems 92.67% were the main causes of their tension.

PHYSICAL PROBLEMS

Health is not only a biological or medical concern, but also a significant personal and social concern. In general, with declining health, individuals can lose their independence, lose social roles, become isolated, experience hardship, be labelled or stigmatized, change their self perception, and some of them may be institutionalized. In India, 45% of the total population, both rural and urban are reported to be suffering from similar chronic afflictions. Illness in most elderly in rural areas is largely from pain in the joints (47.7%), cough (34.5%), blood pressure (6.4%), heart disease (3.7%), piles (3.5%) and diabetes (1.7%). Most of these ailments become chronic as people age into the "old age group". In urban areas there is a dominance of arthritic pain (38.8%), followed by cough related ailments. Changing life styles in urban areas are reflected by an increase in blood pressure (17.5%), heart diseases (6.3%), diabetes (5.3%), and urinary problems. This trend in diseases continues into older age groups. Mortality is however largely from diseases of the circulatory system accounting for about one third of deaths.

With advancing age, physical deterioration and decrease in vitality, elderly exhibit greater vulnerability towards diseases. Accurate diagnosis is very important in the case of aged. Sensible prescribing, using drugs sparingly and discretely, should be the aim. Some of the common old age diseases are:

Degenerative diseases: of blood vessels and heart like arteriosclerosis leading to high blood pressure, coronary and cerebrovascular diseases

which are major causes of death in the aged. Malignant diseases : prevalence and incidence of malignancy is much higher in this group. Diseases of locomotor system: fibrositis, gout, rheumatism, arthritis, osteoarthritis, spondylitis and osteoporosis. Respiratory diseases: such as chronic bronchitis and asthma are more prevalent in this group. Genito-urinary disorders: enlargement of prostate, dysuria, frequency and urgency of micturition, incontinence, of cervix etc. Nutritional and metabolic problems: increase in the incidence of diabetes and nutritional deficiency diseases, indigestion etc. Gastrointestinal disorders: With loss of teeth, atrophy of taste buds and gastric mucosa, the old person can eat only a limited variety of foods. Many among the old develop hiatus hernia and loss of mobility in the intestine due to partial atrophy of smooth muscles. Eye diseases: cataract, glaucoma and retinal disorders. Hearing defects. Dental problems. Accidents: fractures as a result of frequent falls. Due to loss of sensory functions like hearing, vision and touch, they are more prone to accidents. Environmental hazards: noise and air pollution have adverse effects. Older people are susceptible to environmental changes like heat and cold. Loss of immune functions and increase in autoimmune diseases. Older persons suffer from higher incidence of infections and during illness they take much more time to recover and even then, seldom recover to their original health status. Adverse reactions to drugs is commonly seen in elderly patients. Prescription of drugs should be as simple and minimum as possible to avoid adverse reactions to drugs.

There are several physical problems of aged in our country some

are universal and others are specific in there nature. **As Rao K. S. et. al (1996)** observed that " High blood pressure, blindness, arthritis and multiple diseases are the common physical problems among elderly."²⁷

Chadha N. K. et. al. (1996) study namely 'Intergenerational gap and phychosocial health' revealed that impairment of vision, backache, arthritis, blood pressure, bowel irregularities, chest pain, impaired hearing, diabetes, heart disease etc. are the problems which capture the human being in their old age.²⁸

Tulika Sen (1996), in her study namely 'A Health and Socio-economic profile of the Aged Bengali women' observed the physical problems elderly women; respiratory, asthma, cardiac rheumatism, cold- cough, diarrhoea were the most common problems among them.²⁹

Prof. Kumar (1986-87) study revealed that "Old people were suffering from joint pains, falling eye sight, hard of hearing, heart problems and high blood pressure, difficulty in passing decretion, diabetes, cataract etc."³⁰

Dr. Kumar observed in his study some physical problems of elderly women which are given below :

27. Rao K.S., Samiullah S., Koteswaraiah G. and Azmal Basha (1996) The psycho-sociological problems of the disabled rural aged. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.
28. Chadha N. K. et. al. (1996) As above.
29. Tulika Sen (1996), A Health and Socio-economic profile of the Aged Bengali women. Edited & Pub. By Prof. Vinod Kumar, AIIMS, Printed by Balaji Printers, 8703/15, D. B. Gupta Road, Pahar Ganj, New Delhi - 110055.
30. Prof. Kumar (1986-87), Family life and socio-economic problems of the aged.

Table No. 4 (20)**Most Common Chronic Problems of Elderly Women (65+)³¹**

Diseases and disorders	Perecentage affected
Fever	100.0
Cold and cough	100.0
Respiratory infections	64.0
Dysentery and dyspeptic	56.0
Visual impairments	52.0
Cataract	39.0
Hearing impairment	24.0
Swelling of feet	32.0
Difficulty urinating	16.0
Diabetes	29.0

Table No. 4 (21)**Major Disease and Disorders of Elderly Womens (65+)³²**

Diseases and disorders	Perecentage affected
Rheumatoid arthritis	79.0
Hypertension	32.0
Cardio-vascular	28.0
Pulmonary diseases	24.0
Tuberculosis	17.0
Lung malignity's	2.0
Cervical cancer	21.0
Anemia	29.0
Skin disease	18.0
Nervous disorders	24.0
Dementia	31.0
Mental illness	11.0
Depression	93.0

31. Dr. Kumar S. Vijaya (2000), Elderly women in rural India ; Need health policy intervention, Pub. by Health Care Promotion Trust (Regd.), National Institute of Primary Health Care, D-1017, New Friends Colony, New Delhi-110065

32. Dr. Kumar S. Vijaya (2000), As Above.

Table - 4 (22)

Showing Visual problems of respondents

Problem	Yes	No	Total
	F(%)	F(%)	F(%)
Cataracts	128 (42.67%)	172 (57.33%)	300 (100%)
Long sight vision	134 (44.67%)	166 (55.33%)	300 (100%)
Short sight vision	189 (63%)	111 (37%)	300 (100%)
Glaucoma	92 (30.67%)	208 (69.33%)	300 (100%)

From above table it is cleared that 42.67% of the respondents were suffering from Cataracts problems, 44.67% had long sight vision problem, 63% of the respndents were suffering from short sight vision and 30.67% had Glaucoma problem.

Table - 4 (23)

Showing Digestion problem among respondents

Problem	Yes	No	Total
	F(%)	F(%)	F(%)
Gastric	250 (83.33%)	50 (16.67%)	300 (100%)
Pain in feacial exeution	234 (78%)	66 (22%)	300 (100%)
Indigestion	198 (66%)	102 (34%)	300 (100%)
Loss of appitite	227 (75.67%)	73 (24.33%)	300 (100%)

Above table shows that 250 majority of the respondent 83.33% were suffering from the problem of Gastric, 78% had pain in Feacal excretion while 66% of the respondents were sufferer of Indigestion and 75.67% had problem of loss of appitite.

Table- 4 (24)**Showing Heart related problems among respondents**

Problems	Yes F(%)	No F(%)	Total F(%)
High Blood Pressure	203 (67.67%)	97 (32.33%)	300 (100%)
Low Blood Pressure	184 (61.33%)	116 (38.67%)	300 (100%)
High Low Blood Pressure	192 (64%)	108 (36%)	300 (100%)
Hypertension	263 (87.67%)	37 (12.33%)	300 (100%)

The above table shows that 67.67% of the respondents were suffering from high blood pressure, 61.33% from low blood pressure and 64% were from high-low blood pressure, the table also reveals 87.67% of the respondents had the problem of hypertension.

Table - 4 (25)

Showing Bone related problem among respondents

Problem	Yes	No	Total
	F(%)	F(%)	F(%)
Rheumatism	193 (64.33%)	107 (35.67%)	300 (100%)
Joint pain	255 (85%)	45 (15%)	300 (100%)
Back-ache	189 (63%)	111 (37%)	300 (100%)
Feet non sensation	195 (65%)	105 (35%)	300 (100%)

From above table it is cleared that majority of the respondents were suffering from Orthopedical problems in which 64.33% were sufferer of Rheumatism ,85% from Joint pain , 63% of back-ache and 65% were sufferer non-sensation of feet.

Table No - 4 (26)

Showing skin related diseases among respondents

Problems	Yes	No	Total
	F(%)	F(%)	F(%)
Axima	145 (48.33%)	155 (51.67%)	300 (100%)
Itching (Scabies)	175 (58.33%)	125 (41.67%)	300 (100%)
Swelling	202 (67.33%)	98 (32.67%)	300 (100%)

Above table shows that many respondents had been suffering from skin related diseases, in which 48.33% of the respondents were suffering from Axima, 58.33% Itching, and 67.33% had problem of swelling in skin.

Table - 4 (27)**Showing other physical problems of respondents**

Problem	Yes	No	Total
	F(%)	F(%)	F(%)
Impaired Hearing	250 (83.33 %)	50 (16.67%)	300 (100%)
Diabetese	241 (80.33%)	59 (19.67%)	300 (100%)
Asthma	217 (72.33%)	83 (27.67%)	300 (100%)
Tuberculosis	19 (6.33%)	281 (93.67%)	300 (100%)

Above table shows that 83.33 % of the respondents were sufferer from the problems of impaired hearing, 80.33 % from diabetese, while 72.33 % of the respondents had problem of Asthma and the problem of Tuberculosis was not seen 93.67% of the respondent and nearly 6.33% suffering from Tuberculosis.



CHAPTER-V

ROLE OF FAMILY

- Role of family in relation to sleeping arrangement of respondents
- Frequency of food served to the respondents
- Quantity of food provided to the respondents
- Nutrients in the diet of respondents
- Quality of food provided to the respondents by the family
- Treatment seeking behaviour of respondents
- Role of family in relation to providing treatment to respondents
- Role of family about conditions of health cheek-ups and supply of drugs to respondents
- Role of family in connection with entertainment provided to the respondents
- Role of family in connection with emotional behaviour
- Role of family in relation to religious functions

SELF CARE PRACTICES

- Self care practices by the respondents
- Self hygenic activities performed by the respondents
- Preventive self measures taken by the respondents for diseases

ROLE OF FAMILY & SELF CARE PRACTICES BY THE RESPONDENTS

Family is one of the oldest institutions of the world and it is the most important primary group. It is found even in the most primitive of human societies in the world. Since the earliest times in human history the family too, has been constantly known. **Davis** define that "Family is a group of persons whose relations to one another are based upon consanguinity and who are, therefore, kin to another."¹ on the other hand an another sociologist **Clare** said that "Family is a system of relationship existing between parents and children."

Family is the basis of society and cradle of all social activities. family helps its members in performing social life and it is responsible for keeping their members perfect. A family helps is harmonising and balancing social tendencies and it also turns minds of family members physically, mentally and psychologically to adopt to new cultural, and social changes. In fact, whole life of an individual whether he/she is child or old is controlled through the family. significance, importance and values of rights and duties are the product of family life. Respect for the elders and sympathy for the young are lessons of family.

In older days and even now in many parts of the world; for instance in India, the elder to a large extent are cared for at home. Family care of the older person prevalent in India is the best form of insurance for their emotional health and Family care of older persons

¹- Davis, Kingsley, Human society, p. 397

prevalent in India is the best form of insurance for their emotional health and economic security. They are fairly well respected and venerated in the family and the society. This accounts for a very low rate of loneliness in old age in our country. For old aged persons, the traditional family norms and values were a great source of security and care. Joint family met the social, economic and emotional needs of its members. In times of illness distress, destitution and death, joint family served the role of social security and insurance. To the old aged persons, joint family provided not only economic support but emotional and human warmth too. In joint family, the old aged persons never felt unwanted. They got love and care were almost deified.

The children and /or younger siblings are on the frontline to assist their elderly in their needs. However, from older times to present, there have been tremendous increases in life span of people. The increases in longevity have brought in added problems of health and care of older persons. Population aging all over the world is associated with increasing numbers of frail older persons, particularly in older age groups where care many a time make stressful demands on the family carers. Besides ;of course family care may at times provide inadequate care to the needy elderly from a medical and professional perspective.

A large number of older persons as they advances in age need efficient, quality care as they go through period of disability, resulting from multiple chronic conditions and terminal illness. It is true that

while, on the one hand population aging reflects a better living and healthier life style, it also brings in a bigger demand for acute as well as not so acute services. In recent years, palliative care with its focus on controlling pain and other distressing symptoms, easing suffering and enhancing the life that remain and, has become an important part of elderly care mostly in home -setting and a few in hospices, if at all the facility is available.

All over the world, but particularly so in societies where family bonds are strong and integrative, elderly prefer to stay in their homes, cared by their own kith and kin, specifically as they realize the nearness of their life's end days. It is no doubt desirable for the well-being of older persons, to have home care, but at the same time attention is to be given to the protection of elderly in their homes and improving the services rendered to them for their medical and health needs by the family members. Medicine is making big leaps in patient care and families need to keep abreast of these achievements some of the advances are becoming necessary for improving the quality of life of the elderly. It is necessary to recognize in an ageing society, the different changes occurring in older persons care needs. Families along with their elderly have to open themselves to new forms of care whether provided at home or in other setting with the involvement of family members.

Help rendered to elderly members consists of gamut of activities extending from personal care to emotional support and work-pooling

assistance. **Antonucci(1990)** distinguishes three main types of informal support to the elderly people .First the emotional support which involves the provision of moral and psychological support through sympathetic and caring relationships. Second, is the informal support which assists the elderly with the problem solving and decision making. And finally, the instrumental support which takes the form of help with the practical tasks of everyday life.

Through generations and across societies and nations the family has been at the centre stage of informal care of its elderly members despite the impact of societal processes such as accelerated ageing, urbanization and modernization, coupled with migration of young members to urban areas in search of employment. This is likely to pose problems for the care of the elderly in the future .The impact of these societal processes would be felt on family structure and individual lifestyles which, in turn will have a bearing on the conditions of life and welfare care problems of the aged. It will also raise serious financial problems and social tensions. Elder care is a many -sided task that has to be shared by the family ,community, society and the state this paper focusses attention on the role of the family in care - giving of its elderly members.

It performs many functions / roles for the elderly members of its family.These functions/roles are providing housing facilities, economic security,nutrition and entertainment facilities etc. So far as housing facility is concern; it is one of the important need of elderly presons because at this stage they want a place for rest and where they get

love and care. The family satisfies the need of housing as well as affection by human beings. The family also play a role in relation to economic security for the aged. Family's another function is related to providing health care. At the age of 60 years or above a person wants proper care. It provide proper treatment and care to its elderly members. The families provided recreation to its elderly members. It provide entertainment facilities such as radio, television, participation in entertainment programmes etc. The another function which the family performs is of a religious character. Other than these functions the another one which is important and i.e. emotional or psychological function because in it family provide emotional or psychological care to the elderly member of the family. The family satisfies not only the psychological needs of the aged but it also satisfies their desire to love and to be loved and get respect.

There are some responsibilities of families and family should always keep them in considerations. Family should treat aged members with all respect and dignity in all matters, acknowledge the wisdom / expertise of the elder members and seek their advice in family matters, to make them feel wanted and emotionally stable, keep contact with family doctor for regular examination of the elderly at periodic intervals, keeping a note to consult him/her if any unusual or symptom is noticed, improving quality of life being the objective, opportunities be made available to the elderly for recreational facilities and/or religious discourses, and vocational involvement in the company of similar age group population, adjustment in multi-generational families,

understanding priorities and limitation, humanitarian and spiritual approach to elders to prevent privation, deprivation, isolation, loneliness, neglect, abuses and elderly maintenance with dignity in family set up. Several study have been conducted to identify role of family in relation to elderly. Some references are as follows :-

Soldo and Longion (1988) described that Older persons experience multiple needs for support .Functional financial, social and environmental needs often clusters and are provided by the immediate family, mainly by the spouse, co-resident sons, daughters-in-law and proximate but not co-resident daughters.²

Girland et. al. (1978) and Montgomery (1991) revealed that "the exodus to younger people to cities seriously curtails the potential for family support to the elderly but in contrast, sons, more distant relatives and friends are more likely to play a back up role, helping with emergencies and limited time tasks."³

Shabeen Ara (1994) found in her study that living with children is the preferred living arrangement of the aged slum dwellers. Children of 92% of the respondents take care of food and clothing of their aged parents and attend on them in sickness. However only 40.24% of the elderly respondents received financial assistance from sons who lived separately.⁴

On the other hand, **Marulasiddaiah (1969)** revealed in his study

2. Soldo, B. J. and Longion, C. Social and physical environments for the vulnerable aged. In :The Social and Built Environment in an Older Society. Washington, D. C. : National Academy Press. 1988.

3. Girland, B. L. et. al. Personal time dependency in the elderly of New York City : Findings from the U. S.-U. K. Cross National Geriatric Community Study, New York, 1978.

4. Shabeen Ara, Old age among slum dwellers. New Delhi : South Asian Publishers, 1994

of Makunti village in Karnataka found that the old in this village felt they were neither properly cared when ailing, nor were they well fed and clothed by their sons and relatives.⁵ **Usha Rani et. al. (1989)** also observed in their combined study that the aged people were not getting proper care and attention at the time of illness.⁶

Hareven (1981) described that patterns of support and expectations for receiving and providing assistance in old age are part of a continuing process of interaction among parents, children, other kins, and unrelated individuals.⁷

Vijay Kumar (1991) points out about role of family in relation to aged there is a disparity between the perception of problems and issues pertaining to old age by the old themselves and their caregivers.⁸

Phillips (1993) observed that " Care provision by the family is complex and built upon pre-existing relationship ,contacts and reciprocity. Support by family members for crisis and dependency is not automatic and is offered within a social and familial context established over many years."⁹

5. Marulasiaddaiah, H. Old people of Makunti, Dharwad: Karnataka University, 1969.

6. Usha Rani, Old age security and utility of children. In Pati R.N. and Jena, B. (eds) Aged in India. New Delhi : Ashish Publishing House, 1989.

7. Hareven, T. K. Historical changes in the timing of family transitions : their impact on generational relations . In March, J. G. Fogel, R. W. et. al. (eds.), Aging : Stability and Change in the Family, New York; Academic Press, pp. 143-165, 1981.

8. Vijay Kumar, S. 'Family life and socio - economic problems of the aged' , New Delhi : Ashish Publishing House . 1991.

9. Phillips, D. Formal and informal support system : Accommodation and services. Paper presented at the Indo-UK workshop on Public Health Implications of Ageing in India. New Delhi : ICMR, 1993.

Vatuk, (1989) wrote n the basis of his observation that on the other hand, an older women is a widow ; she is unlikely to be able to hold an extended household together. Such a person becomes dependent on one of her sons and thus on a daughter -in- law as well. In either instance, the role transition that an older women and her caregiver must negotiate is problematic, given the widespread belief that "only a daughter can really serve her parents with all her heart".¹⁰

Prof. Goyal Sunil et. al. (1997 : 45) also wrote on the basis of their study that " Every fifth senior citizen takes only one meal a day. One third (33%) of the respondent aged are lucky enough to have three meals a day. Aged who are staying with their children or relations were getting three meals a day."¹¹

In this study attempts were being made to identify the role of family in relation to elderly women. The detailed finings are given in following tables :

10. Vatuk, S. Withdrawal and disengagement as a cultural response to ageing in India. In: Fry, C.L. (ed), Aging in Culture and Society .New York :J. F. Bergin publishers pp 101-125, 1989

11. Goyal sunil (et. al.); Problems of the tribal aged : Need to integrate them into the family ; 'Samajik-Sahyog' National Quarterly Research Journal; pub. by Research Management (Srikrishna Shikshan Sansthan), Ujjain (M.P.), Vol. 21(6), Jan-Feb-March, 1997, p.45.

Table No - 5 (1)

Showing role of family in relation to sleeping arrangement of respondents

Arrangement	Yes	No	No reply	Total
	F(%)	F(%)	F(%)	F(%)
Separate room	102 (34%)	166 (55.33%)	32 (10.67%)	300 (100%)
Separate bed	202 (67.33%)	69 (23%)	29 (9.67%)	300 (100%)
Cleaning of clothes	118 (39.33%)	142 (47.34%)	40 (13.33%)	300 (100%)
Cleaning of room	92 (30.67%)	178 (59.33%)	30 (10%)	300 (100%)

It had been seen from the above table that 55.33% of the respondents have not separated room while, 34% have separate room.

In context of bed 67.33% of the respondents have separate bed and 23% have not. It is cleanly depicted in the table regarding cleaning of clothes 47.34% of the respondents said that their clothes were not regularly washed by the family members,while 39.33% of the respondent's clothes regularly washed by the family members. About cleaning of room 59.33% of the respondents said that their family members didn't cleaned their room regularly, there were of those respondents who had not separate room 30.67% to the respondents said that their room was regularly cleaned by the family members.

Table- 5 (2)**Showing frequency of food serve to the respondents**

Frequency	Frequency	Percentage
Once	89	29.67
Two times	132	44.00
Three times	79	26.33
Total	300	100.00

The frequency of food served by the family members reflects the degree of care shown for the elderly women. In above context 44% given of the respondents said that they were given food two times in a day, while 29.67% were given food once and 26.33% of the respondents were given food three times in a day.

Table - 5 (3)**Showing quantity of food provided to the respondents**

Quantity of food	Frequency	Percentage
Meagre	73	24.34
Sufficient	103	34.33
As per need	124	41.33
Total	300	100.00

This table reveals information on quantity of food served to the elderly women. 41.33% of the respondents said that food served to them were as per their need, 34.33% replied that was sufficient and according to rest 24.34% of the respondents food provided to them was meagre in quantity.

Food given as meagre in quantity was seen largely in case elderly belonging to lower economic strata.

Table 5 (4)

Showing nutrients in the diet of respondents

Nutrients	Yes	No	Total
	F(%)	F(%)	F(%)
Milk	89 (29.67%)	217 (70.33%)	300 (100%)
Fruits	117 (39%)	183 (61%)	300 (100%)
Paneer	70 (23.33%)	230 (76.67%)	300 (100%)
Meat	46 (15.33%)	254 (84.67%)	300 (100%)

The above table tells about nutrients which was provided by the family in the diet of respondents. The majority of 211 respondents (70.33%) said that they were not getting milk in their diet while only 29.66% were getting it. About fruits 61% of them said that it was not included in their diet and 39% were get it. When the respondents were asked that they were getting pareer or not 76.67% said no and merely 23.33% of the respondents response was yes, 84.67% said that meat was not given in their diet while only 15.33% said yes.

On the basis of responses it can be said that the diet which was provided to the elderly women by the family members was not full

of nutrients and healthy.

Table - 5 (5)

Showing quality of food provided by the family to the respondents

Type of food	Frequency	Percentage
Rich food	56	18.67
Simple food	175	58.33
Poor food	69	23.00
Total	300	100.00

The above table shows that 58.33% of the respondents' considered the quality of food provided to them by the family was simple , 23% said it was poor in quality and rest 18.67% of the respondents considered their food as rich quality.

Table - 5 (6)

Showing treatment seeking behaviour of respondents

Treatment	Frequency	Percentage
At once	37	12.33
Obstacle in walking	98	32.67
At serious pain	124	41.33
See and wait	41	13.67
Total	300	100.00

When respondents were asked about their treatment seeking behaviour. The majority of 124 respondents 41.33% told that they seek physicians at the time of 'serious pain', 32.67% attended clinics at the eve of on 'obstacle in walking' followed by 13.67% 'see and wait'

of disease and 12.33% seek 'treatment at once'.

Table - 5 (7)

Showing role of family in relation to providing treatment to the respondents

Medical treatment	Frequency	Percentage
Private hospital	81	27%
Govt. hospital	127	42.33
Domestic treatment	63	21.00
Hakim / Vaidyas	29	9.67
Total	300	100.00

From this table it had been driven that 42.33% respondent's family provide them treatment of government hospital, 27% of the family members take elderly women of their family for treatment in private hospital, while 21% said they were given domestic treatment by their family members and just 9.67% respondent's family preferred Hakim/Vaidyas for treatment of elderly.

Table 5 (8)

Showing role of family about condition of health check-ups and supply of drugs to respondents

Condition of treatment	Frequency	Percentage
Regular	63	21.00
Sometime	131	43.67
Not Provided	106	35.33
Total	300	100.00

Above table clearly depicts that when the respondents were enquired about the conditions of health check -ups and supply of drugs; 43.67% of the respondents said that they were provided sometimes, while 63 respondents (21%) said regularly and the remaining 35.33% they were not given any type of treatment and drugs.

TABLE - 5 (9)

**Showing role of family in connection with entertainment
provided to the respondents**

Facilities	Yes	No	Total
	F(%)	F(%)	F(%)
T.V.	105 (35%)	195 (65%)	300 (100%)
Radio	98 (32.67%)	202 (67.33%)	300 (100%)
Tape	83 (27.67%)	217 (72.33%)	300 (100%)
Religious seminars	144 (48%)	156 (52%)	300 (100%)

When the respondents were enquired about the entertainment facilities available for them within the family and which were provided to the respondents by the family members. 195 majority of respondents (65%) said that they had no facility of 'television' while 35% were enjoying their life by watching television. In context of 'radio' 67.33% respondent's families not provided them this facility of recreation and only 32.67% had radio. A large number of 217 respondents (72.33%)

had not the facility of 'tape' while merely 27.67% were enjoying with tape which was provided to the respondents by their family members.

So far as facility of participation in religious seminars was concerned 156 respondents (52%) were never enjoyed this opportunity, their family members were not taken out for participating in these seminars while 48% respondents said they were attended religious seminars.

TABLE - 5 (10)

Showing role of family in connection with emotional behaviour

Emotional behaviour	Always	Sometime	Never	Total
	F(%)	F(%)	F(%)	F(%)
1. Association of Son & his wife	76 (25.34%)	109 (36.33%)	115 (38.33%)	300 (100%)
2. Consideration of needs	77 (25.66%)	89 (29.66%)	134 (44.66%)	300 (100%)
3. Adequate care Given	82 (27.33%)	95 (31.67%)	123 (41%)	300 (100%)
4. Association liked by grandsons	54 (18%)	166 (55.33%)	80 (26.67%)	300 (100%)

Above table tells that majority of 115 respondents (38.33%) sons and their wives never associate with respondents, 109 respondents (36.33%) were sometimes associated by sons and their wives while 25.34% respondents were always associated.

When the respondents were enquired whether or not their needs were considered by family members the majority of 134 respondents (44.66%) never considered, 29.66% sometimes considered and 25.66% were always considered the needs of respondents.

41% respondents were never given adequate care by family, 31.67% were sometime given care and only 27.33% respondents were always given care.

When the respondents were asked that they were liked by their grand sons 55.33% were 'sometime' liked, 26.67% were 'never' liked and merely 18% were 'always' liked by their grand sons.

TABLE - 5 (11)

Showing role of family in relation to religious functions

Religious functions	Always F(%)	Sometime F(%)	Never F(%)	Total F(%)
1. For temple visiting	93 (31%)	118 (39.33%)	89 (29.67%)	300 (100%)
2. Outing after 5ys	41 (13.67%)	69 (22.33%)	192 (64%)	300 (100%)
3. For hearing/ Katha Bahagwat	90 (30%)	132 (44%)	78 (26%)	300 (100%)

When the respondents were asked about the religious functions performed by family members, in relation to temple visiting 39.33% respondents were sometime taken to visit the temples, 31% always given chance to visit the temples and 29.67% respondents were not allowed to visit the temple.

So far as outing facilities was concerned 192 respondents (64%) were never taken out to pilgrimage 22.33% sometimes gone for outing and merely 13.67% enjoyed this opportunity always.

So far as listening of katha/Bhagwat 132 respondents 44% sometimes attended katha/Bhagwat listening, 30% always used to attended katha/Bhagwat while 26% respondents never attended katha /Bhagwat.

SELF CARE PRACTICES BY THE ELDERLY

Every individual has a right and desire to be in state of perfect health. This implies not only physical but also psychological, social and spiritual well-being. Preventive and therapeutic interventions for various disorders are not enough to achieve these objectives. It is equally important to protect and maintain health by several other measures which should include not only preventive medical care but also many other steps directed to achieve happiness and well-being from angles other than physical. Regular application of these measures during different stages of life time can frequently, delay the onset and progression of various impairments, diseases and disabilities and thus help maintain and protect the individual current level of health to the extent possible. Even reversal of some impairments can be achieved. Although it is never too late to look after one's health but in order to achieve healthy state in old age, such measures should be actively adopted at least from the middle age onwards.¹²

Self caring is an important practice to maintain health .It is convenient and cost effective method consisting of some easy to perform DOs and DONTs in day to day life. Many elderly know the importance of these practices but may or may not perform them regularly. Yet, many individuals completely lack the knowledge and motivation to carry on these practices altogether.

Maintenance of ideal weight, exercise proper diet and life styles

12. Prof. Vinod Kumar (2000) Self care practices for the elderly, published by health care promotion trust. (Regd.), National Institute of Primary Health Care. Edited by Dr. P.C.Bhatla, D-1017, New Friends Colony, New Delhi - 110065.

and an adequate social and spiritual interaction are essential to maintain sound health.

(i) **Personal Cleanliness** like regular brushing of teeth, cleaning the mouth, frequent washing of hands and taking bath daily are important. Wearing clean clothes, regular nail cutting, hair cleaning and avoidance of foot trauma are additional measures.

(ii) **Bowel Movements** should be ensured at fixed regular timings during the day. Constipation is a common problems in old age. High roughage diet and exercise will help moving the bowels regularly and prevent constipation. Frequent use of laxatives should be avoided. If bowel habits become abnormal, one should report the doctor at earliest.

(iii) **Exercise** includes both physical and yogic exercises. Unless contraindicated due presence of certain problems like heart disease, physical exercise is very useful. Moderate to brisk walking for upto 30-45 minutes daily is convenient. This improves blood circulation in almost all parts of body and maintains normal function. Exercise prevents constipation, bone loss and fractures, promotes good sleep and helps reducing overweightness, cholesterol, high blood pressure and in diabetic individuals the high blood sugars. For arthritis, specific exercises depending on the involved joints will be useful, while for heart patients, only light exercises should be recommended. However, in any case during old age, exertion should be avoided. Some yogic practices may be difficult to carry out with advancing age but pranayama or the breathing exercises are easy to perform.

(iv) **Food and Nutrition** play important role in maintaining health and preventing diseases. Although elderly have caloric requirement of 10-15% less than compared to adults, deficient nutrition is very common in old age especially in villages. General principles include adequate intake of nutritive foods and avoidance of fatty, fried and sugary preparations. Excessive salt should also be avoided. Adequate intake of leafy vegetables, fibre diet, milk, vitamin -containing foods and enough water and fluids supplementation of essential food element in case of inability to consume ordinary solid foods as in patients without teeth are other measures. It is useful to provide educative charts to health workers on nutritive value of common foods and general principles of diet to make their task simpler. Proper dietetic practices exert general beneficial effects in malnutrition, obesity, arthritis and in subjects without teeth and more specifically, useful effects in diseases like high blood pressure (salt restriction), heart disease (fat restriction), diabetes (sugar restriction) and many other disorders. Prolonged fasting and overeating are to be avoided. Any unexplained weight loss should be reported immediately.

(v) **Life Styles** have become increasingly unhealthy in modern stressful society. Addictions, tensions and sedentariness are more common. Smoking should be strongly discouraged as it contributes to disorders of lungs, heart, brain, peripheral blood vessels and diseases like cancers. Consumption of chewable and other forms of tobacco and excessive use of mouth freshners like various masalas should also be avioded. Excesssivs alcohol intake is know to lead to liver disease,

stomach ulcer, nutritional deficiency, heart ailment, dependency and social problems and should also therefore be discouraged.

(vi) **Sound Sleep** for at least five to six hours is essential for health. To much extent, this can be achieved by avoiding prologed sleep or frequent naps during the day, undertaking adequate exercise, involving oneself in social interaction, remaining occupied in routine chores and by observing food discipline. Soft and thick mattresses and pillows should also be avoided especially by those having back problems.

(vii) **Social and Recreational Activity** is as important as health-related activity. This helps preventing loneliness, isolation, depression, anxiety and dementia and is the best method to maintain good mental health. Cultivating friendships, interactions with neighbours and peer groups, participating in adult education programmes and undertaking vocational activity and hobbies such as gardening and indoor games are useful mechanisms for social interaction. Participating in recreational activities, prayers, divine songs (bhajans), religious discourses and group reminiscences are also useful.

(viii) **Resource Utilisation Activities** undertaken by elderly, give them a feeling of belonging, satisfaction and even empowerment all of which go a long way to promote mental health. This however depends on their functional independence and potential. Activities for which elderly can encouraged include imparting of training by female elderly for antenatal and postnatal care, income generating activities like basket making, caring of children at home, participating in community

developmental work and in management of day care centres and others organisations for elderly care. If possible, some control should be exercised on personal and family finances.

(xi) **Spiritualism** is practised by different individuals to different extent. However in many countries stepping into old age is a fairly strong event that attracts the individual away from materialistic world .Most elderly begin to participate consciously or unconsciously in philosophy of spiritualism. They begin to differentiate more firmly between right and wrong, between good and bad, between violence and non-violence etc. They also become increasingly involved with places of worship, ashrams and yoga centres in accordance with their own religious, sectoral and philosophical faith. Since such practices are known to provide solace, happiness and relaxation all leading to good mental health, elderly population should be encouraged and inducted to adopt these practices . Further, in order to facilitate these practices, importance of well defined procedures based on an integrated manner should be emphasized. These include physical postures (including asanas, rejuvenating and cleansing techniques), breath holding (pranayama), mental exercises (meditation) and life styles. Such integrated approach has preventive, promotive, curative and rehabilitative value.

(x) **Health Check - ups** for special functions like vision, mobility, hearing, memory and mastication should be help regularly together with a check on body weight, blood pressure, blood sugar and cholesterol at periodic intervals. Any abnormal features like lump in

TABLE - 5 (12)

Showing self care practices by the respondents

Practices	Ever F(%)	Never F(%)	Sometimes F(%)	Total F(%)
Daily walk	85 (28.33%)	98 (32.67%)	117 (39%)	300 (100%)
Yoga practice	40 (13.33%)	191 (63.67%)	69 (23%)	300 (100%)
Physical check-up	68 (22.67%)	111 (37%)	121 (40.33%)	300 (100%)
Self purchase drugs	67 (22.33%)	101 (33.67%)	132 (44%)	300 (100%)

The above table shows that 39% of respondents were go for walk sometime, while 32.67% of the respondents never go for a walk and lastly 28.33% were go for walk daily.

When the respondents were asked about yoga practices 191 majority of the respondents (63.67%) said that they were never practicing yoga, 23% sometime doing yoga exercise, and the remaining 13.33% practicing yoga regularly.

In context of self health check-up 121 of the respondents (40.33%) were sometime go for their health check-up while 37% didn't and the remaining 22.67% of the respondents regularly were go for their health check-up.

132 majority of the respondents (44%) were bring their medicine

sometimes, 33.67% of the respondents never like to bring their medicine and the rest 22.33% said that they were always bring their medicine.

Table - 5 (13)

Showing self hygienic activities performed by the respondents

Hygenic Activities	Yes F(%)	No F(%)	Sometimes F(%)	Total F(%)
Bathing	230 (76.67%)	41 (13.67%)	29 (9.67%)	300 (100%)
Washing Clothes	168 (56%)	62 (20.67%)	70 (23.33%)	300 (100%)
Combing	225 (75%)	32 (10.67%)	43 (14.33%)	300 (100%)
Nail Cutting	239 (79.67%)	25 (8.33%)	36 (12%)	300 (100%)

Above table shows those hygiene activities which were performed by the respondents themselves,in this regard 76.67% were capable of bathing by themselves while 13.67% were unable to bath on their own, 56% were capable of washing their clothes on their own while 23.33% wash their clothes sometimes. 75% respondents comb their hair by themselves while 14.33% did it sometimes. In context of nail cutting by themselves 79.67% were able to do this by themselves, 12.1% did it sometimes while 8.33% were not able to cut their nails by themselves.

Table - 5 (14)

Showing preventive self measures taken by respondents for diseases

Preventive Measures	Yes	No	Total
	F(%)	F(%)	F(%)
Good food taking	102 (34%)	198 (66%)	300 (100%)
Exercise	89 (29.67%)	211 (70.33%)	300 (100%)
Personal Hygiene	97 (32.33%)	203 (67.67%)	300 (100%)
Keep Environment	90 (30%)	210 (70%)	300 (100%)
Clean	94 (31.33%)	206 (68.67%)	300 (100%)
Live in clean home	99 (33%)	201 (67%)	300 (100%)
Preventive Vaccination & Medicines			

Above table shows preventive measures taken out by the respondents to avoid themselves from diseases. The majority of 198 respondents (66%) did not take care for the good food taking while 34% respondents said that they do care for the food they were intaking 70.33% of the respondents were not given importance to exercise and merely 29.67% respondents do exercise.

So for as personal hygiene was concerned the majority of 67.67%

respondents didn't take care for it while 32.33% were taken care, followed by 70% respondents were not given importance to clean environment and 68.67% not to clean home and 30% respondents said that they keep the environment clean, 31.33% respondents said that they were resided in clean home.

When the respondents were enquired about preventive vaccination and medicines 201 respondents (67%) said that they didn't prefer vaccination and medicines while only 33% of them used preventive vaccination and medicines to avoid themselves from diseases.



CHAPTER-VI

ISSUE RELATED TO AGED

- Self observed issues of elderly
- Issues before families regarding elders.
- Issues of care of elders by their family members.
- Welfare and rehabilitation issues before government in relation to aged
- Issues before Voluntary Organisation / Non-government organisation about elders
- Issues before social organisation about aged
- Issues before physicians in relation to elders
- Issues related to medical care and services for elderly
- Other issues related to elders.

ISSUES RELATED TO AGED

There is no a single society that has no problem at all because society is a group of people who have their needs. For fulfilling the needs, people face problem when the impact of these problems appear before society are called issues. These issues are those which are connected with that problem, which hinders social progress and well-being of the people. It is essential to conduct a micro study of every issues necessary to solve the problem of issues. If we ignore these issues and its nucleus of the study, then they will effect adversely.

In general words, we mean issues are those situation which attract our attention towards themselves. Issues are those challenges, if they were not scientifically diagnose or treated than the social physics will be ill, sick diseased and full of social pathology.

Public issues in general is that which effects a large number of people. It is the aim of sociologist to know how far the public issues emerge in the functional social structures. He studies the action system of different social relation effect the social life. For the solution of these issues he observes, how to re-organised the social structure and social system, in this way theory could be linked with a scientific perceptives.

Walsh et. al (1961) defined, "Social issues as deviation against social ideals which are solved through collective indevours."¹ On the

1- Walsh, Mary E. and Fursey, Paul H., Social Problems and Social Action (3rd Ed), Prentice Hall, Englewood Cliffs, New Jersey, 1961

other hand **Reinhardt (1952)** explained, "Social issues as that state in which a segment of society or large part of society is affected and its impact or result whose treatment is merely possible by collective representation of society,"²

Carr (1955) described the time of emergence of social issues that "Social issues appear at that time when we are aware about a certain problem when a gulf is created between our interest and realities."³

Social issues have their own significance, at one side they provide knowledge about the various dimensions of the problem, on the other hand, they motivate to accept the challenges. When any sort of issues related to any certain problem do not come in light till individual, society and nation do not become serious. It is essential for innovation, creative thinking and for new composition some issues to be presented before us to extent the scope of our thinking, feeling and doing because we become aware to solve the problems through the study of issues. Issues are not a simple condition for a society but they are also responsible for disorganisation of the society. They have their own importance if we have no issues, we cannot get stimulation for new thinking in our daily lives. When we perform any action -reaction and interaction , we become enable to consider on the issues.

Society has several issues here, we concern only to social issues which comprise several sub issues such as; issues, related to education , marriage, caste, religion, population and health. At present the

2- Reinhardt, James M., Meadows Paul and Gillette, John M., Social Problems and Social Policy, American Book Co., New York, 1952.

3-Carr, Lowell I., Analytical Sociology, Harper, New York, 1955

issue of old age is very important, this issue is related with those who are backbone of today. This section

at present is suffering a lot. Tokyo i. e. a great exporter in the world says that in coming years the increasing population of olds can be a great problem before great economic advanced countries of the world. Report further highlights that East Asia has to draw his attention from highly gained areas of profit such as energy, electronics devices, designing and cultural properties. The reason would be increasing number of pension, health and security measures of oldmen and they have to include various issues related to ageing on priorities. On 4th July which was 'World Population Day', experts delivered their lectures that aged for their leading life will expense their savings, it means that economically advanced countries will have lesser capital for investment and that will hinder economical growth rate.

It is like to be consider that in the population of Asia 3.88 billion the percentage of 65+ is six percent. According to Popualtion Reference Bureau, a group of researcher says, the old age population will be increased upto 17 precent in 2025. Owing to increasing life expectancy age and disliking of youths for marriges. They say that we have to seek ways and means to control over reproduction. In Akita Ki Zia Hoka University of Japan, a one of associate professor of Economics namely Manabu Shimasawa told that present symptoms tell about economical system of Asia that ageing is increasing like leaves and bound. He further told that demographic attack in the from of tax

and burden of pension will be appear in the form of improvident before the world.⁴

In this chapter various issues related to the elderly women will be discussed. The need of study was motivated towards misearable conditions of elderly women. Their problems cannot be ignored because of they are very important heritage, and their experiences presents society got shape. If issues related to them, come before us, they should be considered by society and nation seriously as well as essentially. We only then, be succeeded to achieve the caues and effects of the issues in relation to elderly women.

THE ISSUES BEFORE THE ELDERLY

A very depressing situation of being deprived of an opportunity to regular activity (productive materially or socially) arises when the elderly feels the rigor of being unwanted. Boredom and disinterest supervenes to further add to the depression, leading further to being a burden on the family and thus being the victim of neglect and of being considered as of no consequence. Isolation in sharing joys and sorrows of life, appears to take hold and the elderly gets lost. He needs to take control and discipline himself to remain in the mainstream to be acknowledged as a useful member all his life.

It is time, which gradually tells on the individual life, leading it to the stage of being old and later physically discarded. Preparation for reaching the old stage gradually andd imperceptably, losing the grip on physical activity as adviser, preceptor or administrator or

guide, assures being wanted. This is possible if experience turns into expertise and that is available as a gift for the asking by the society. It is the way to being accepted and respected for the benefits that accrue from the advice, guidance and crystallised way of approach to problems.

Much depends how one takes responsibilities of life during youth and how he builds a halo around him of efficiency, dependability and credibility. The approach assures others to then seek help, later advice and still later guidance in the field specialised with understanding by the elderly. It is possible with accepting the quality and quantity of change in thinking, in acceptability and dealing. Each person thus carves a place for himself in a vocation that gets identified and individualised. It is work that continues, its quality may undergo change but the basic nucleus on involvement remains and this involvement is what keeps one busy and wanted as composite part of any social set up.

Engaging oneself in an on-going activity even as a hobby, creates an important nucleus for projecting something unusual and interesting and attention-catching. A man in his life needs to get involved in two-three or more different vocations or assignments, in addition to the one which finds him in employment. It is the interest maintained and perfection continued to be attained, that bears results in later life. Working for social and voluntary organisations for public welfare, brings in satisfaction and happiness of being useful to society. Each individual

has his own trait or guna to make him distinguished in any field. It is development of his attributes that makes him wanted as he contributes his extraordinary talent, even in old age.

It is important to plan for the future and not live from day to day. Various financial schemes are available which need attention more in earlier part of life to lay the foundation of economic security in latter life. Another aspect is investment in hard work to attain perfection that attracts respect and status. The perfection has to be kept up for the elderly to remain in demand still. Another involvement lies in their demonstration in ethical, moral and spiritual bearing to life and its activities. This approach towards truth and service with faith and devotion, creates an aura of respectfulness and divinity. It is so since the very fact that only truthful and righteous approach will be projected, taught and practised that develop an inner strength to meet challenges, crises and difficulties boldly. This is what keeps the flag of confidence flying, that acts as the magnet for the elderly to be always consulted. Here attempts were being made to study self observed issues of elderly and the findings are given in following tables :-

Table No. - 6 (1)

Showing self observed issues of elderly

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Isolation & loneliness	216 (72%)	66 (22%)	15 (5%)	300 (100%)
2. Un respect	197 (65.66%)	71 (23.67%)	32 (10.67%)	300 (100%)
3. Feeling of socially unfit	205 (68.33%)	77 (25.67%)	18 (6%)	300 (100%)
4. Lack of systemised planning for future	163 (54.33%)	129 (43%)	08 (2.67%)	300 (100%)
5. Occupationally uninvolvement	215 (71.67%)	46 (15.33%)	39 (13%)	300 (100%)

When respondents were enquired about self-observed issues, 216 majority of respondent (72%) replied that they felt isolation and lonliness by 22% said they did not 197 respondents (65.66%) said that they were not given respect while 23.66% were not in favour. On the other hand 205 respondents (68.33%) of the total felt that they were socially unfit. When they were asked about their systemised planning for future 54.33% said there was lack of such planning while 43% respondent said this is not and issue. Lostly when the respondents were asked thier involvement in the occupation majority of 215 respondents (71.67%) said that elderly's occupationally uninvolvement was an considerable issue while only 15.33% were not

favouring it.

ISSUES BEFORE THE FAMILIES

Identify the specific needs of the elderly in the family and ensure specified approach to alleviating the same. This would ensure emotional stability. Provide respect and dignity to the elderly to prevent isolation, loneliness and a feeling of being unwanted, through a pragmatic approach in their involvement in family relationships and decisions, etc.

Ensure financial stability through demonstration of providing financial assistance as much as possible. Create a protocol of ensuring medical aid as it becomes necessary by providing proper nutrition and medicines and nursing care. Maintenance of health care will create confidence as well as ensure proper attention to general health care.

Keep contact with community services through family doctor for optimal use at proper time. This would ensure freedom from bouts of depression and/or lack of interest by the elderly. Maintenance of a Health Card will create confidence as well as ensure proper attention to general health care. In this study attempts have been made to know the issues before families in relation to elderly. The findings are given in following tables :-

Table No. - 6 (2)

Showing issues before families regarding elders

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Lack of emotional stability	225 (75%)	43 (14.33%)	32 (10.67%)	300 (100%)
2. Ignoring in family decision making process	251 (83.67%)	19 (6.33%)	30 (10%)	300 (100%)
3. Lack of financial Aid	259 (86.33%)	30 (10%)	11 (3.67%)	300 (100%)
4. Lack of medical aid-nutrition and care	264 (88%)	22 (7.33%)	14 (4.67%)	300 (100%)

Above table reveals the issues which were in front of families regarding elders, the majority of 225 (75%) respondents said emotionally unsatbility of family was an important issue while 14.33% respondents didn't feel the same condition. In relation to ignoring olds in family decision making process 251(83.67%) respondents were favouring it and said that it is an considerable issue and merely 10% respondents were not favouring of that issue. 86.33% respondents said that families were not given financial aid to the elderds while this isssue was not the issue for 10% respondents. On the other hand 264 respondents (88%) said that providing medical aid-nutrition and care to the aged member of the family is an important issue and most of

the were fail to provide them that facilities while only 7.33% respondents said no.

Table No. - 6 (3)

Showing issues of care of elders by their family members

Issues	Yes F (%)	No F (%)	No Reply F (%)	Total F (%)
1. Lack of emotional care	257 (85.67%)	28 (9.33%)	15 (5%)	300 (100%)
2. Carelessness of families about advices given by physicians	221 (73.67%)	46 (15.33%)	33 (11%)	300 (100%)
3. No help in their physical impairments	235 (78.33%)	35 (11.67%)	30 (10%)	300 (100%)

Above table shows those issues which are related to care of elders provided by the family members. In this regard 257 respondents (85.67%) said that the care of aged is affected, due to lack of emotional care while 9.33% were not take it as an issue and merely 5% were unable to give any response. 221 respondents (73.66%) said that it is also an important issue before family members related to their carelessness about advices given by the physicians for the care of elders, 15.33% respondents said no and rest 11% didn't reply. 78.33% of the respondents said that at this stage of life a person become physically incapable and at that time majority of the families didn't provide help to elderly member of their family, so it become an issue

regarding care of the aged while 11.67% said no and the remaining 10% were unable to reply.

ISSUES BEFORE THE GOVERNMENT

To ascertain through surveys, the total dimension of the problems of the elderly including their numbers, social and economic status, their care in the families, the care of the destitute elderly. To formulate and enact and implement the National Policy on Ageing in order to provide a comprehensive coverage of management of health and other problems in the overall care of the elderly (viz. social, physical, psycho-emotional and mental) and to create resources therefor.

To provide old age pensions and/or other benefits including recreational and vocational facilities, medical and health care facilities and their involvement in work/activity suitable to their training aptitude and skills to instill confidence in them of being productive and wanted.

To provide appropriate facilities for terminal care through well designed institutional care, domicillary care and health care protocols to ensure good and dignified death.

To create special comprehensive care teams of sociologists, social workers, nursing care, physicians, hospices and hospitals, physiotherapists and other experts in preventing loss of vision and hearing and locomotions, etc while promoting quality of life of the elderly. To construct or help construct special Elderly Homes/ Day Care Centers/Counselling centers/Special out-patient/ hospital/ hospices etc. for providing necessary care. Several enquiries were made from respondents to study elderly related issues before government. The results are presented through following table.

Table No. - 6(4)

**Showing welfare and rehabilitation issues before Govt. in
relation to aged**

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Formulation of experts group for promotion in life quality of elders	244 (81.33%)	21 (7%)	35 (11.67%)	300 (100%)
2. Identification of overall problems of elders	251 (83.67%)	17 (5.67%)	32 (10.66%)	300 (100%)
3. Issues of formulation of national policy & its implementation	220 (73.33%)	34 (11.34%)	46 (15.33%)	300 (100%)
4. Issues of old age pension & other facilities	248 (82.67%)	18 (6%)	34 (11.33%)	300 (100%)
5. Issues of essential care	233 (77.67%)	27 (9%)	40 (13.33%)	300 (100%)
6. Issues of establishment of old homes/ care center	221 (73.67%)	36 (12%)	43 (14.33%)	300 (100%)
7. Issues of establishment of counselling centres	215 (71.67%)	35 (11.67%)	50 (16.66%)	300 (100%)

When the respondents were enquired about those welfare and rehabilitation issues which are related to aged and those are challenges before the government, 244 majority of the respondents (81.33%) said that formulation of experts group for promotion in life quality of elders is one of the big issue before the govt. while 11.67% respondents were not replied. 251 (83.67%) respondents said that firstly government should identify overall problems of elders while 10.66% respondents were unable to reply.

73.33% of the respondents replied that its also an important issue before government that they formulate national policy and also implement it, 15.33% respondents didn't reply in this regard.

In context of issue related to essential care of aged 77.67% were favouring that it is an welfare and rehabilitation issue before government and merely 13.33% didn't reply. Establishment of old homes and care centers is also an considerable issue, majority of 73.67% respondents were in favour of that while 14.33% did n't give any reply. 71.67% respondents said that establishment of counselling centres is important issue in front of the government which should be looked after for their welfare while 16.66% were not able to give any response.

ISSUES BEFORE THE VHA'S/NGO'S

It shall be expedient to compile information on the health problems of the elderly. Side by side the socioeconomic problems and the psycho-emotional problems shall also have to be identified. Non

utilisation of time effectively by the elderly would need finalisation of recommendations thereon to take them out of isolation and wilderness in quest of a satisfying job.

The NGO's could initiate family life education for maintaining joint family system and demonstrate the repercussion of nuclear families on the elderly and their rehabilitation in some job/vacation for them to gainfully spend time outside home. It is in this position, when he is productive that he retains his status and respect and individuality.

A very essential requirement for the elderly is for them to be rehabilitated in some vocational work preferably of their interest best essentially needing their concentration and acting as an outlet for their submerged feelings of dependence and uselessness in the society. A detailed plan be prepared in consultation with them to chalk out rehabilitation programmes.

It is very important for the elderly to feel responsible. Any assignment to them acts as a challenge to be met. In its fulfillment there develops an inner sense of satisfaction, their confidence is raised, their determination gets a boost and their morale as productive and wanted members of the society, also gets elevated. It is for the NGO's to define duties relevant to specific needs for each elderly placed in the homes or in the community. A broad outline of such patterns could be suggested and institution of a Counselling Centre would meet this demand to render suitable advice.

This is the long term proposition that raises the confidence of the people. They gradually look forward to their being continuously working and their rightful place in a society is maintained. Such workshops could identify a set of such retirement plans to suit all categories of the elderly- educated, uneducated, rural, urban, poor or welloff, with

families or without families. Plans for those who are single with no near relatives could include their adoption by certain families or if the elderly is rich, he himself can adopt a young couple to meet his emotional requirements. In this study attempts have been made to know the issues before voluntary organisation and Non-government organisation about elderly, the findings are given in following table.

Table No. - 6 (5)
showing issues before voluntary organisation and
Non-government organisation about elders

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Training problems of rehabilitation	179 (59.67%)	84 (28%)	37 (12.33%)	300 (100%)
2. Issue of providing them respectful roles	203 (67.67%)	69 (23%)	28 (9.33%)	300 (100%)
3. Planning of welfare schemes through their participation	240 (80%)	47 (15.67%)	13 (4.33%)	300 (100%)
4. Issue of organising workshop for retirement scheme	198 (66%)	62 (20.67%)	40 (13.33%)	300 (100%)
5. Formulation of respectful environment for elders	284 (94.67%)	00 (-)	16 (5.33%)	300 (100%)

Above table shows the issues before voluntary organisation and non-governmental organisation in the upliftment of elderly . In context of training problem of rehabilitation 179 respondents (59.67%) that is the issue before these organisation while 28% said no. 67.67% respondents were favouring that providing them respectful roles is one of the important issue and only 23% replied no. Majority of 240 respondents (80%) were favoured that participation of aged in planning welfare schemes is one of the considerable issue in front of such type of organisation while 15.67% respondents did not consider it. In context of organising work for retirement schemes, 66% respondents replied yes followed by majority of 94.67% said that formulation of respectful environment for elders is an important issue before voluntary and non-government organisations.

ISSUES BEFORE THE SOCIAL ORGANISATIONS WORKING SPECIFICALLY FOR THE ELDERLY

It shall be expedient to define the area of operation by the organisation (society). Within that area, a list of elderly population, be prepared and information sought on a well structured questionnaire. It shall be the duty of the particular individuals to prepare the background information on each problem of this elderly population on the basis of the data collected. From this will ensure the defined requirements of the elderly meeting their real needs as well as their felt needs. It shall be the responsibility of the society then to plan programmes and projects and meet their financial responsibility. The implementation plans will thus take birth and a systematic counselling advice or other help etc. will be ensured to this identified group, who

will not need to be shifted to elders rehabilitation rooms or homes under consideration.

To make all citizens aware of the problems faced by the elderly and the treatment meted out to them as a debt of gratitude for their life long contribution to the welfare of the society. The organisations could publicise the inherent weakness of the society in this regard suggesting measures to mitigate the hardships to the elderly.

The message of due and adequate care of the elderly and the respect for the aged has to be propagated in the families specially among the young couples. Probably education could start from schools and universities. Dignity of the aged is the honour of the young. Some difference of opinion or variations in approach, may become necessary to make people feel the presence of their seniors among them and also make them realise the need to make the elderly comfortable through love and compassion.

After all ageing is a process everyone has to face. It is just a question of time. Demonstration of care, concern and consideration for the aged by the younger people, can definitely make their infants and children learn how to treat elders with respect. To establish special homes/daycare centres/institutions for the aged.

The organisation could procure land on which such facilities be built up. Guidance clinics on health matters and vocational hobbies could be set up. Projects on instruction to elderly to learn self care in this regard as well as counselling services on all others problems, could be made available. Of course such efforts would meet only a tiny fraction of the elderly group but in time, similar set-up would come up by efforts of VHA's/NGO's An elderly person engaged in work of

his interest, projects the labour of love and the remains happily occupied and does never feels lonely and isolated.

To provide instructional guides to let elders build their confidence, feel happy and occupied and ever wanting to give of their best. Each organisation should be seriously concerned to produce special literature for different groups of the elderly to make them aware of their potentials and their responsibilities in their own welfare as well. It should prepare health education material for the aged and organise special seminars/discussion with their involvement. Efforts would certainly prepare documents on Terminal Care to let the elderly die with dignity. To assess the capability, resourcefulness and mobilisation of the same gainfully, in the promotion of care of the elderly.

It is a type of introspective study to know weaknesses and strengths. Weakness will be reduced by extra efforts on a co-operative basis while strengths would be gainfully utilized for equipping to carry out our objectives. Someone has pioneered the movement with confidence and dignity. Those who join now have to show their zeal leadership, statesmanship and above all their devotion and dedication to fulfil the mission. Before that even, they have to come forward to tell the organisation of their full potential and their contribution in cash and kind to enable projects to be formulated under its leadership.

This is the direction that each organisation has to take. This is the obligation that the society has to fulfil and this is the contribution that can set examples for them to multiply all over. The elderly deserves honour not pity and deserve respect and not charities. Here attempts were being made to study the issues before social organisation and the findings are given in following table :-

Table No.- 6 (6)**Showing issues before social organisation about aged**

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Implementation of programmes in their area	183 (61%)	102 (34%)	15 (5%)	300 (100%)
2. Identification of real & essential needs of elders	198 (66%)	84 (28%)	18 (6%)	300 (100%)
3. Fulfilment of finance responsibilities	186 (62%)	101 (33.67%)	13 (4.33%)	300 (100%)
4. Aware citizens about problems of elders	198 (66%)	90 (30%)	12 (4%)	300 (100%)
5. Service them like (PITRARIN)	229 (76.33%)	62 (20.67%)	09 (3%)	300 (100%)
6. Establish day care homes & special homes	176 (58.67%)	94 (31.33%)	30 (10%)	300 (100%)
7- Provide nurses to special homes	147 (49%)	114 (38%)	39 (13%)	300 (100%)
8- Assess capabilities & abilities about promotion of services	153 (51%)	112 (37.33%)	35 (11.67%)	300 (100%)

When the respondents were enquired about those issues which are in front of those social organisations which are working especially in the field of old age, and for their upliftment, in this regard 183 respondents (61%) said that it is an issue in front of these organisations to implement programmes in those areas where olds are living while 34% were not in favour.

So far as identification of real and essential needs of elders were concerned the majority of 198 respondents (66%) said yes and they thought that it is an important issue before social organisation and 28% said no and only 6% were unable to give any response. 62% respondents said that in old age majority of the elderly population facing financial problems so its also an big issue while 33.67% were not in favour. The majority of 198 (66%) respondents said that it's the responsibility of social organisation that they spread awareness among citizens about problems of elders and 30% said that it is not an issue.

76.33% of the respondents said that in present time the condition of olds is not in a good condition so it is the issue before social organisations that they provide service to the aged like "Pitrarin" while 20.67% were not in favour.

On the other hand 58.67% of the respondents were favouring that establishment of day care homes/centres and special homes is considerable issue before these organisations and 31.33% said no. 49% respondents said that in old age a person become pessimistic and

felt lonely so there is a need to provide nurses to keep them happy but 38% didn't think so. In the context of assessing capabilities and abilities about promotion of services 51% respondents said that it is an issue before social organisations while 37.33% said no and the remaining 11.67% were unable to give any response.

ISSUES BEFORE THE PRIMARY HEALTH CARE PHYSICIANS

Elderly people are generally more pessimistic and more fatalistic about their health, believing as they do, that old age will bring in natural problems, which they have to accept and bear their consequences e.g., loneliness, social isolation and dependency. Clinical care of the elderly by primary care doctors would ensure.

High standard of clinical skills knowing that their problems can be more demanding or more challenging. Functional orientation to application of knowledge about elderly is encouraged to act as the central feature of primary medical care. Effective preventive and therapeutic strategies through organised team approach. Provide relief from treatable symptoms, e.g., pain, incontinence, hearing and visual problems, etc. Prevention of iatrogenic diseases which may threaten because of multiple drug therapy and for wrong medicine-taking by the elderly.

Primary care doctors have to essentially provide the following. Primary geriatric care to prevent and treat health problems that adversely affect including providing domiciliary care, emotional care,

psychological care; social support to supplement care by families; co-ordinating management of multiple therapy for multiple problems; relief from loss of physical or functional ability, e.g., hearing, sight, mobility, communication, speech etc.

Terminal care to ensure peaceful death and side by side ensuring quality of life while living. The primary care physician can mobilise and concentrate on professional skills and attitudes to influence the quality of care as follows; recognise atypical presentation of disease; recognise acute problems which may scare the elderly; make accurate diagnosis and prescribe the minimum, cautious as he will be, supplementing newer medication to already prescribed drugs; co-ordinate management through judicious and appropriate help of others, e.g. hospitals, consultants, etc.

Be alert to common problems of the elderly, e.g. hearing and visual loss incontinence, CVAs, osteoporosis, osteoarthritis, falls, dementia, depression, metabolic/neoplastic disease, etc.; know about local health and social services; in matters of prescribing drugs to be careful to manage conditions without drugs if possible, use smallest dose regimen, be alert to drug interactions and toxic reactions; primary care includes managerial and advocacy role of doctor for planning adequate curative treatment. In this study attempts have been made to know the issues before physicians in relation to elderly the results are presented through following table.

Table No. - 6 (7)**Showing issues before physicians in relation to elders**

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Olds are pessimistic	137 (45.67%)	105 (35%)	58 (19.33%)	300 (100%)
2. Untrained medical officer in geriatrics	225 (75%)	34 (11.33%)	41 (13.67%)	300 (100%)
3. Doctors' psycho inefficiency about elders care	216 (72%)	55 (18.33%)	29 (9.67%)	300 (100%)

Above table shows issues before physicians in relation to elders.

Majority of 137 (45.67%) respondents felt that due to olds being pessimistic it is difficult for physicians to provide required treatment while 35% respondents didn't feel it is an issue. In regard to untrained medical officers in the field of geriatrics majority of 225 respondents (75%) that it is an important issue, on the other hand 13.67% were unable to give any response. In context of doctors' psycho inefficiency about elder care 216 (72%) respondents were favouring while 18.33% didn't think it is an issue.

ISSUES BEFORE GERIATRIC RESEARCH IN PRIMARY CARE

Although the number of elderly is steadily increasing and more and more problems are being identified, the need for changes in UG/ PG medical education had not yet been addressed to treat geriatrics

as a distinct discipline (like pediatrics in the case of children). The following need urgent attention.

Continuing education for primary care doctors has become necessary for them to keep pace with growing knowledge and designing and developing strategies. Their exposure to acquiring expertise to train the practising colleagues is another area of study for them to enhance skills.

A case in view is the under-utilisation of senior primary care physicians and the psychiatrists and psychogeriatrician in diagnosis and management of dementia, psychosis or depression or lack of interest or initiative and the well to work by the elderly.

Primary care physicians need to learn judicious use of technology since inadequate diagnosis and under-treatment or over-treatment or over-use of technology are just as dangerous, in view of multiplicity of morbidity. Prescribing medicine judiciously in the elderly is another point in view because of pharma-kinetics/pharma-dynamics of drugs in the elderly.

Some of the important areas of research would include the following:-

Studying the medicine-taking by the elderly and monitoring adverse drug reactions thereby identifying factors responsible for induction of iatrogenic disease. An index of geriatrics literature needs identification and compilation. This is a resource material for primary care physicians.

How to improve quality of life in the elderly in enhancing their functional ability or utilizing their expertise for their own rehabilitation. Evaluation of interventional approach to the health problems to serve as primary prevention of morbidity and their complications. Educational strategies to guide the elderly in the natural history of disease and interventions by primary doctors to reduce the incidence of chronic disease through development of health promotion and prevention. Assessing the utility of screening and surveillance of elderly to identify risk factors and functional ability.

How far can the involvement of social scientists and psychologists be useful in approaches and follow-up technology. Study the possibility of geriatric care through special set up units -a team approach. Self care by the elderly -explore ways of monitoring and thereby improving efficiency of primary health care team. Health service research into care of elderly to bring about strategies of change, both in the elderly as well in the system of delivery of health care including availability, accessibility and providing emergency care and support to families with elderly through domiciliary care by health professionals. To study how an experienced doctor can demonstrate skills and their values to younger doctors and other health professionals. To identify common health problems in the elderly with a view to laying emphasis on their teaching and management as a part of curriculum change.

To assess the techniques and psycho-socio-promotional management or terminal care and support during bereavement to the

families. Standards of what constitutes good and acceptable primary health care do not exist. A study to define the outcome and organisation of primary care services by the physicians, needs to be undertaken under the defined parameters. Defining these parameters will lead to identifying common ailments and attaining relief therefrom in order to ensure functional ability and mobility, emotional stability and also indicate the range of professional skills and services, and their availability and accessibility for acute and chronic morbidity care, including attention to support family and improving communication between health and social and/or community services. Assessing wider implications or improvement of professional techniques by primary care doctors through review of clinical care research and education support to them and in matters of recognition and mobilising support of other health professionals and scope of delegation of duties to the latter. In our country the support of national councils of medical research and/or educational institutional will become pressing and urgent to design projects/surveys/studies etc. through technical and financial support to various groups of research teams at different level with strategic co-ordination support at national level. This only can assure better care of the elderly and better quality of life for them. Several enquiries were made from respondents to study issues related to medical care and services for elderly people. The findings are given in following tables.

Table No. - 6 (8)**Showing issues related to medical care and services for elderly**

Issues	Yes	No	No Reply	Total
	F (%)	F (%)	F (%)	F (%)
1. Lack of separate geriatric deptt. in Distt Hospital	257 (85.67%)	12 (4%)	31 (10.33%)	300 (100%)
2. Lack of specialization in geriatrics	108 (36%)	57 (19%)	135 (45%)	300 (100%)
3. Issues of non utilization of elders experiences in their care	254 (84.67%)	16 (5.33%)	30 (10%)	300 (100%)
4. Lack of research on geriatrics	84 (28%)	67 (22.33%)	149 (49.67%)	300 (100%)

Above table shows opinion of respondents regarding issues related to medical care and rehabilitation of elders before government, the majority of 257 (85.67%) respondents were in favour that there should be a separate geriatric department in Distt. hospitals, 10.33% didn't reply and merely 4% were not considering it as an issue. In regard lack of specialization in geriatrics 45% respondents were unable to give any response, 36% said that government should do something in this field and the remaining 19% said no.

The majority of 254 respondents (84.67%) said that it is an issue or challenge that government should utilize experiences of elderly

persons in their care, 10% were unable to give any response while 5.33% said no. In context of research in geriatrics majority of 49.67% were unable to realise the importance of it while 28% feels it is that it is issue.

Other than above mentioned issues there are some issues which are also effect the life of aged. Migration from rural to urban areas has its own adverse effect on the aged citizens. As the young people are moving out from the rural areas in search of employment to the urban areas, the care and support for the elders at their place of origin is bound to be affected. To be specific, migration to urban areas separates the rural youth from his traditional parents, and hence reduces the frequency and intimacy of contact, with the aged parents.

Those elderly who prefer to move with their children are also affected since this might encounter special stress as the new environment might be less supportive to them. For instance, people moving from the interior part to the village to a metropolitan city like Bombay would definitely have difficulty to adjust with the way of living in the city.

Other than migration change in the family size is also an issue related to care of aged. Three decades back it was hard to see a family with few children say one or two and with the existence of joint family system, taking care of the aged was not really a problem in those days. With the intervention of the Government through family planning programmes, the picture has changed from large to small family size.

This has its own effect on the aged citizens. As a matter of fact, with smaller number of children, the burden of providing care for the elderly parents has become heavier i.e., with less number to share this responsibility. This could be one reason for the general criticism that youngsters are not taking care of their aged parents, because of which they are left alone. However, there is another school of thought which says that when that family is small, interaction between families become stronger, which calls for an in-depth investigation.

Till a decade ago, Indians have lived in an extended family structure. In such a kind of family structure, land or property used to be owned by the household i.e., aged person and he used to have complete authority over the familial and social matters. His decisions would be final and he would be given due respect by the youngsters.

In the present situation, there has been a shift from the joint to nuclear family. The relationship between the aged persons and the youngsters in the nuclear family is very formal where the former has no full authority over familial or social matters. His opinion is no longer being sought as the young would prefer to consult their own peers who are more likely to understand (*Baginda, 1987*).⁵ Several enquiries were made from the respondents to study some important issues related to aged. The results are presented through following table :-

5. Baginda A. M. The emerging issues of the aging of population : Malaysia, In : Population Aging : Review of emerging issue, Asian Population Studies, No. 80, United Nations Bangkok.

Table No. - 6 (9)

Showing other issues related to aged

Issues	Agree	Disagree	Indefinite	Total
	F (%)	F (%)	F (%)	F (%)
1. Outside service of sons	267 (89%)	20 (6.67%)	13 (4.33%)	300 (100%)
2. Youngers dislike opinion of olds	243 (81%)	25 (8.33%)	32 (10.67%)	300 (100%)
3. Change in family size effect care of olds	257 (85.67%)	27 (9%)	16 (5.33%)	300 (100%)

The above table tells that majority of 267 (89%) respondents were agree that outside service of sons is an important issue related to olds because it effects care of olds, 6.67% disagree while merely 4.33% respondents were indefinite about it.

When the respondents were enquired whether youngers dislike opinion of olds, the majority of 243 (81%) respondents were agree and said that disliking of youngers is also an considerable issue. While 10.67% respondents indefinite ans merely 8.33% were disagree in this regard.

Issue related to change in family size and its effect on the care of olds, the majority of 257 (85.67%) respondents were agree, while 9% respondents said that they were disagree that change in family size effected care of olds and the remaining 5.33% were indefinite in this context.



CHAPTER-VII

OPINION OF RESPONDENTS ABOUT OLD AGE WELFARE PROGRAMME

- 25% concession in Railways
- Old age pension
- Old age homes
- Day care centers
- Standard deduction of Rs. 15000/- provided by the Govt.
- Mobile medical care scheme
- Pension scheme
- Senior citizen saving scheme
- Maintenance Act (Code of Criminal Procedure, 1973)

OPINION OF RESPONDENTS ABOUT OLD AGE WELFARE PROGRAMMES

In human society, the scatterness of members is easily observed. According to Tarde, Opinion is 'will' or "commitment". McDugal and Lewale also discussed, opinion as general will. Opinion manifests one's stable ideology. Some people become very active on a certain opinion. The cooperation of other members or differences about a certain act is called opinion of people. Opinion neither related to adequate knowledge nor temporary. Ginsberg, opinion is heap of ideas and beliefs of men in society ; in which there is stability and not merely temporary reaction but that is not based on scientific and natural ideology. Kuppuswamy writes "Public opinion consists of opinions held people of a similar or larger community about a particular problem at a certain time". In the words of Sohn Deway, 'Public opinion is judgement which is formed and entertainment by those who constitute the public and is about public affair." Daniel Katz, opinion is an unique mixture of reactions and concensus. Blumer (1993), "Public opinion is summary of various ideas among people which he calls Central Tendency." Bonner views that opinion is changeable in accordance with population structure of problem. Thus opinion is social production which is result of interaction of several minds. In this study attempts were being made to reveal the opinion of elderly women about various old age welfare programme but before that need

to know those programmes.

In mythology and religious scriptures, irrespective of region and religion, the moral and material support to the aged has been regarded as highest virtue of human being. However, at present India is passing through a phase of rapid socio-economic transformation. Sustained economic development since independence has brought in its train many important changes in the social profile of the people. The rapid urbanisation has been associated with shortage of housing accommodation in the cities and the high rental which acts as a severe constraint on the joint family system. In fact, the joint family system is gradually breaking down giving way to atomistic family. Forces of modernisation, technological changes and mobility have introduced changes in the lifestyle and values of the people which have adversely affected traditional respects as well as attitude of sympathy and care for the aged. Migration of the younger people from rural areas to the cities and towns increases the vulnerability of the old who stay behind.

Increasing literacy amongst women accompanied by their employment outside the home in offices and in factories leave no time for those women to take care of the old at home. The high cost of living and changing priorities affect the intra family distribution of income in favour of the younger generation. Hence the old people have been at the receiving end of these socio-economic changes.

Due to the changing socio-economic structure of society, traditional social security system can no longer provide comprehensive social

support to the aged. These is, thus an urgent need to supplement the traditional family support systems with infrastructure alternative, community and social support systems and if necessary, statutory backing to enable the existing socio-economic strutures to withstand the stresses and strains and to provide services to make it possible for the aged to live with dignity and respect within the family fold and in the society. Many efforts have been taken by the international bodies, Government & non-governmental organisation for the welfare and upliftment of aged.

On the international level efforts being made by the United Nation Organisation (U.N.O.) U.N.O. have stated its concerns to look after the aged. In regard to this field, a world aged assembly was organised in Vienna in the year 1982, in which on international programme for aged was accepted Every year on the first of October Aged Day is celebrated and year 1999 was celebrated as 'International Aged year'. UNO has forwarded some schemes in relation to aged which were.

(i) Research should conducted in order to the social economic, physical condition of aged and various type of disease they suffer from.

(ii) Persons who are engaged in formulation of policies should made a ware with state and condition of aged so that they know the aware requires to be worked out.

(iii) Those organisations should be promoted which are actively participating in development programmes, formulation of policies for the aged.

CONSTITUTIONAL PROVISIONS

The constitution makers have rightly inserted an article under the Directive Principles of State Policy, i.e. Art.41 which runs as follows:

"The state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, OLD AGE, sickness and disablement and in other cases of undeserved want"

LEGISLATIVE PROVISIONS

For the welfare of elderly in the Income-tax Act, 1961, a provision i.e. section 88B was inserted by finance Act ,1992. This provision provides for rebate of Income-tax in case of individuals of 65 years and above. The aforesaid provision reads as follows: " 88B. An assessee, being an individual resident in India, who is of the age of 65 years or more at any time during the previous year and whose gross total income does not exceed 100,000 rupees shall be entitled to a deduction from the amount of Income-tax (as computed before allowing the deduction under chapter VIII) on his total income with which he is chargeable for any assessment year of an amount equal to 40 per cent of such Income-tax."

Earlier a relief for the elderly people was granted in the Compulsory Deposit Scheme (Income-tax Payers Act, 1974). Under this Act persons liable to make compulsory deposit did not include persons of more than 65 years of age. Earlier the age limit was 70 years which was

reduced to 65 years by an amendment made in 1983 in the Compulsory Deposit Scheme Income-tax Payer Act, 1974.

In the Delhi Rent Control Act, 1958 for retiring persons who are the landlords, a summary scheme for eviction of their tenants was provided in section 14B and 14C of that Act. These provisions were inserted by an amendment made in 1988. The amending Act of 1988 carved out more classes of landlords to enable them to recover immediate possession of premises let out by them through introduction of section 14B to 14D. While released or retired persons from armed forces or the dependents of the members of the armed forces who had been killed in action are covered by section 14B, Delhi Administration are covered by section 14C and widows are covered by section 14D.

JUDICIAL ACTIVISM

"Pension is a socio-economic justice measure providing relief when advancing age gradually but irrevocably impairs capacity to stand on one's feet. In the course of transformation of society from feudal to welfare and as socialistic thinking acquired respectability, State obligation to provide security in old age, an escape from undeserved want was recognized and as a first step, pension was treated not only as a reward for past services but with a view to helping the employee to avoid destitution in old age.

On the issue as to whether liberalised pension scheme will be applicable irrespective of their date of retirement arose in the context of a memorandum of Government of India by which the formula of

computation of pension was liberalised but made it applicable to Government servants who were in service on March 31, 1979 and retired from service on or after that date. While striking down the portion of the memorandum which restricted the benefit of liberalised pension to those retiring on or after March 31, 1979, the court further observed.

"If the State considered it necessary to liberalise the pension scheme, we find no rational principle behind it for granting these benefits only to those retiring subsequent to that date, simultaneously denying the same to those prior to that date. If the liberalisation was considered necessary for augmenting social security in old age to Government servants, then, those who retired earlier cannot be worst off than, those who retired later. Therefore, this devision which classified pensioners into two classes is not based on any rational principle and if the rational principle is one of dividing pensioners with a view to give something more to persons otherwise equally placed, it would be discriminatory.

The artificial division thus has absolutely no nexus to the object sought to be achieved by liberalising the pension scheme. In fact, this arbitrary decision has not only no nexus to the liberalised pension scheme but it is counter productive and runs counter to whole gamut of pension scheme. The equal treatment guaranteed in article 14 is wholly violated in as much as the Pension Rules being statutory in character, since the specified date, the rules accord differential and

discriminatory treatment to equals in the matter of commutation of pension".

WELFARE SCHEMES

In pursuance of these commitments of the State towards welfare of the aged, the State Governments have been providing old age pensions, maintaining old age Homes for the destitutes aged and providing grants-in-aid to voluntary organisations maintaining such Homes. At present Government of India is making assistance to voluntary organisations under the General Grant-in-aid Scheme in the field of Social welfare for the aged. The existing schemes are as follows:

- (i) Day Care Centres for the aged,
- (ii) Old Age Homes, and
- (iii) Mobile Medicare Services for the Aged.

The Ministry of Welfare is administering the above schemes and providing Grant-in-Aid on the basis of application received through the State Governments. The Ministry of Welfare is implementing the assistance Scheme with effect from 1.4.1993. During 1993-94, there is a budget provision of Rs. 300 lakhs under the Scheme of Assistance to Voluntary Organisations for programmes relating to the Aged. There are at present 51 Old Age Homes and 147 Day Care Centres running in the country with help of the above Scheme.

The Ministry of Railways has extended 25 per cent concession in Second Class Mail/Express Fares when travelling beyond 500 Kms. by

the aged (above 60 years) under a Scheme " Senior Citizens Concessions". Further a provisions has been made by the Indian Railways to allot lower berths for the Senior Citizens.

The Constitution of India recognizes the duty of the State towards the elderly. According to Article 41. "The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement and in other cases of undeserved want." section 125 (d) of the criminal procedure code (1973) makes it incumbent for a person having sufficient means to maintain his father or mother who is unable to maintain himself or herself, and on getting proof of such neglect or refusal , a first class magistrate may order such person to make a monthly allowance not exceeding Rs. 500/- A recent court judgement has interpreted the provision to include daughters. The Hindu Adoption and Maintenance Act, 1956, too, recognizes the obligation of a person to maintain his or her aged or infirm parents (Section 30 (3)).

On the other hand many non-government organisation also made some efforts for the welfare of aged. **Helpage India** :- This non-government organisation was established in England in the year 1978 in the name of "Help the aged society" with its main objective to secure the right of aged and to look after them. Its main area of work are.

- (i) To create awareness among youths regarding the need of aged.(ii)
- To establish shelter homes and mobile medical facilities for the aged.

(iii) Provide cure and rehabilitation to the incapable aged. (iv) Under the scheme of "to from on God father" to help the aged living below poverty line sothat they can be rehabilitated.

Age care India :- This non-governments organisation was establish in the year 1980. its main objectives are.

(i) Person more than age of 50 years whether male or female should be provided educational entertainment, social cultural and spiritual services through residential and institutional facilities. (ii) To provide medical facilities to the aged. (iii) To formulate programme to provide partial employment to the by which they can generate income to improve their economic condition. (iv) To study problems of aged and conduct survey.

Non government oganisation also play some important role for the upliftment, rehabilitation and welfare of aged. At the non-governmental level also unified body should take the lead in developing a master strategy for implementing the maximum possible measures for elderly.

These bodies should begin by publishing a material to highlight various geriatric problems and their possible solutions, at periodic intervals. They should also coordinate and avoid duplication of efforts by various voluntary agencies working in this field.

An attempt should be made to work out a loose Federation of Societies concerning ageing.

For Retirement planning projects, per-retirement associations

should be set up, both at central and state levels. Voluntary agencies should play important role in their establishment.

Organise SELF HELP groups of elderly persons : provide all round conselling, including advice on financial investments to ensure regular income; encourage developing hobbies by the elderly; arrange talks/seminars/workshops to frame guidelines for improving their quality of life; act as the agency to provide advocacy for the elderly presons welfare; organise specialised camp-service eg. cataract operations, physical care,including regular medical check-up, diabetes detection, cancer, detection, terminal care, nursing care, nutrition advice, physiotherapy etc.; promote awareness of the need for care / rehabilitation of the elderly in families and in communities; organise Day Care Centres/ Counselling Centres for the care of the elderly including setting up of physicio-therapy units; prepare a statewise or an All India Directory of old Age Homes and/or Day Care Centres including designs module of a each and/or economics of such units ins particular for the destitute elderly; design and organise fund raising drives to finance running projects/programmes.

The study of opinion of community in very important. That is why social scientists often try their level best to know, seek and collect opinions of people in relation to cause and effect relation of any social phenomena, problem and issues . The study of opinion of people is done to know the temperature of social being about any certain or gerenal problems to assess the extent of problems .The information

pertaining to people opinion is also important to diagnosis that is predisposing as well as precipitating factors of the social problem.

Study of opinions of public is also significant to planner so that they can identify the adversities of society. Knowledge of opinion of public is also essential to executives of programmes and organisation to keep an serious considerations in implementation of the welfare programme. Data in connection of opinion is too important to legislators. Assessment of plan, policy or programme is often done on the basis of opinion of people. Alterations ,additions and modifications are observed according to the opinions of the society in programme implementation . Any sort of evaluation is carried out by government or non government organisation through collecting opinion of people in relation to subject and objective of problem.

Several enquiries were made from respondents to know their opinion about various welfare measures provided by the government & non-government organisation. The results are presented through following tables.

Table No. - 7 (1)**Showing opinion of respondents regarding 25% concession
in Railways**

Opinion	Frequency	Percentage
Affirmative	245	81.67
Negative	16	5.33
Indefinite	39	13.00
Total	300	100.00

Above table shows the opinion of the respondents regarding 25% of the concession in railways travelling for the senior citizens; 245 of the respondents (81.67%) out of the total were answered in affirmative , while 13% of the respondents indefinite and the remaining 5.33% replied in negative.

Table No. - 7 (2)**Showing views of respondents about Old Age Pension**

Views	Frequency	Percentage
Affirmative	172	57.33
Negative	86	28.67
Indefinite	42	14.00
Total	300	100.00

Above table shows the views of respondents in regard to their 'Old Age Pension'. In which 172 of the respondents (57.33%) were replied in affirmative while 86 respondents (28.67%) answered in negative and the remaining 42 respondents (14%) were indefinite about it.

Table No. - 7 (3)**Showing opinion of respondents regarding Old Age Homes**

Opinion	Frequency	Percentage
Positive	143	47.67%
Negative	90	30.00
Neutral	67	22.33
Total	300	100.00

Above table shows the effect created by the 'Old Age Homes' and

opinion of elderly women regarding that majority 143 of the respondents which were 47.67% feel it has positive while 30% of the total respondents feel negative and the remaining 22.33% of the respondents feel it's effect was neutral.

Table No. - 7 (4)**Showing views of respondents about Day Care Centres**

Views	Frequency	Percentage
Good	127	42.33
Bad	94	31.34
Normal	79	26.33
Total	300	100.00

Table showing views of respondents about 'Day Care Ceatre' which are running for the care of elderly. In this regard 127 respondents (42.33%) were having good views. On the other hand 94 respondents (31.34%) were having bad and the remaining 26.33% were having normal views.

Table No. - 7 (5)**Showing opinion of respondents in regard to Standard****Deduction of Rs. 15000/- provided by the Govt.**

Opinion	Frequency	Percentage
Affirmative	96	32.00
Negative	65	21.67
Indefinite	139	46.33
Total	300	100.00

Above table shows the opinion of the respondents in regard to 'Standard deduction of Rs.15000 which is given by the government. In this regard 139 respondents (46.33%) were indefinite while 96 respondents (32%) were answered in affirmative and the remaining 65 respondents (21.67%) replied in negative in this context.

Table - 7 (6)

Showing opinion of respondents regarding Mobile Medical Care Scheme

Views	Frequency	Percentage
Favourable	84	28.00
Unfavourable	99	33.00
Indefinite	117	39.00
Total	300	100.00

Above table give a perspective of opinion of the respondents regarding 'Mobile Medical Care Scheme' in which 117 respondents (39%) were indefinite while 33% respondents were having unfavourable opinion in this regard and rest 84 respondents (28%) answered in favour of it.

Table No. - 7 (7)

Showing opinion of respondents regarding Pension Scheme

Opinion	Frequency	Percentage
Positive	189	63.00
Negative	30	10.00
Indefinite	81	27.00
Total	300	100.00

Above table shows the opinion of respondents in regard to 'Pension Scheme' provided to government and semi-government employees, out of the total 189 respondents (63%) were replied positively about pension scheme, while 27% of them were indefinite and the merely 10% of the respondents were having negative opinion.

Table No. - 7 (8)**Showing views of respondents about 'Senior Citizen Saving Scheme'**

Views	Frequency	Percentage
Positive	203	67.67
Negative	41	13.67
Neutral	56	18.66
Total	300	100.00

Above table gives a clear picture of the views of respondents about 'Senior Citizen Saving Scheme' in which 203 of the respondents (67.67%) of the total had positive views, 18.66% of them reacted neutrally ,while remaining 13.67% of the respondents had negative views.

Table No. - 7 (9)**Showing opinion of respondents regarding provision of Maintenance Act (Code of Criminal Procedure-1973)**

Opinion	Frequency	Percentage
Possible	130	43.33
Negative	79	26.33
Neutral	91	30.34
Total	300	100.00

Above table showing the opinion of the respondents in context of the provision of the 'Maintenance Act' in which 130 majority of the respondents (43.33%) of the total were having positive view, while 30.34% of the respondents were behaved neutrally and rest 79 respondents (26.33%) having negative views.



CHAPTER-VIII

CONCLUSION

LIMITATION OF STUDY

SUGGESTIONS

SUMMARY

The objective of the present study was to explore the status and various problems faced by the elderly women along with the exploration regarding the role of family, self care practices. Issues and opinion about various welfare programmes available to the elderly were also the major focus of the analysis. This study was conducted in urban area of Jhansi. A total sample of 300 elderly women has been selected through random sampling technique. The data have been collected through a structured interview schedule.

1. SOCIO-DEMOGRAPHIC FEATURES OF RESPONDENTS

(i) Age of respondents - In this study elderly women were selected who were at the age of 60+. The majority of respondents were belonged to the age group of 60-65.

(ii) Caste - The sample consists of respondents belonging to variegated caste groups - General, Backward Schedule Caste and Muslim Community respondents were included in the sample, in which the highest percentage of respondents were belonged to Backward caste.

(iii) Educational status - The educational status in this study reflected that the proportion of illiterate elderly women was higher .

(iv) Occupation - Majority of 195 (65%) respondents were

unemployed and they were not engaged in any type of productive work.

(v) **Income** - Majority of the respondent's family income was under the income group of Rs. 1001-1500.

(vi) **Marital status** - Majority of the respondents were widows and the elders widows are identified as a special concern group in view of their increasing numbers and dependency .

(vii) **Family** - Family structure of the respondents was studied and it was found that majority of respondents were coming from joint families.

(viii) **Type of house** - Majority of the respondents were lived in pucca houses.

(xi) **Housing facilities** -The findings showed that majority of respondents had housing facilities in their houses such as tap water, electricity, bathroom, kitchen and yard.

2 (A). SOCIAL STATUS OF ELDERLY WOMEN

(i) **Social status of elderly women** - As regards that social status of elderly women, the majority of women were not asked by society and they were not given importance and majority of them were not participated in the social programmes or activities. They were not getting respect from their children and majority of them were not getting invitation on the basis of caste. Majority of the

respondents were often enjoyed the association of their friends.

(ii) Memberships of various organization - Majority of the elderly women were not recognized by social, cultural and religious organizations.

(iii) Interpersonal relationship - So far as the interpersonal relationship was concerned, the majority of respondents were having bitter relation with their family members.

(iv) Acceptance of elderly women by their family- As regards acceptance of respondents, the majority of elderly women were tolerated by their family members.

(v) Economic status of respondents- Majority of 72.67% of the elderly women were dependent on others to fulfil their requirements and needs.

(vi) Living arrangement of elderly women- So far as the living arrangement of respondents was concerned majority of respondents were living with only their children.

(vii) Individual freedom of respondents - As regards that individual freedom of elderly women was concerned; (a) the majority of respondents were given lesser opportunities in decision - making process, (b) no freedom to control over the family and majority of them had lesser freedom in personal matter as well as to fulfill their personal interests.

(viii) Ownership of property - Majority of the respondents were not the owner of house nor had bank account and land in their names. The findings revealed that majority of the elderly women had lower economic status.

2 (B) PROBLEMS AMONG ELDERLY WOMEN

I. SOCIAL PROBLEMS OF RESPONDENTS

Social problems of the respondents were studied and it was found that majority of the respondents were sometimes able to meet with outsiders.

As regards respect given to respondent's friends by the family members, majority of the family members not respected the friends of elderly women.

Majority of the respondents neither associated with society nor they occupied headship status in the family.

II. ECONOMICAL PROBLEMS OF RESPONDENTS

(i) Dependency status - Majority of the respondents 72.67% were fully dependent on others to fulfil their necessities because in that age they were not able to do work and physically they were weak.

(ii) Way of getting pocket money - Majority of the respondents were getting pocket money from their families on demand.

(iii) Source of medical expenses / daily economic needs -

Majority of the respondents received financial help for their medical treatment from their sons. Majority of the respondents were getting financial help from their sons to fulfil their daily economic needs.

III. PSYCHOLOGICAL PROBLEMS

(i) Feeling about their lives - As regards feeling of respondents about their lives, majority of the respondents (63%) were worried in their lives and they were having negative attitude towards their lives.

(ii) Various psycho-problems - From the entire sample it was found that majority of the respondents had various type of psycho problems such as lack of sound sleep, suffering from the problem of obstinacy and majority of the respondents felt irritation in their behaviour

(iii) Problem of Dementia- Dementia was the problem which was largely seen in old age and here majority of the respondents were sufferer of severe stage of Dementia.

(iv) Feeling of respondents about themselves in the family-
The gathered information related to feelings of respondents about themselves in the family reflected that majority of the respondents felt neglected; decreased importance in the family; loneliness and feeling of insecurity.

(v) Causes of tensions- So far as the causes of tension was concerned, the findings revealed that there was tension between

mother and daughter-in-law, insufficient housing space, conflict between son and daughter-in-law, drug addiction of son and health problems were the main causes of tensions of respondents.

IV. PHYSICAL PROBLEMS

(i) Visual problems- Majority of the respondents were having the problem of short eye sight .

(ii) Digestion problems - So far as the digestion problems of respondents was concerned, majority of the respondents were suffering from the digestion, such as gastric, indigestion, pain in feacal excretion and loss of appitite.

(iii) Heart problems - Majority of the respondents were having heart problems, they were sufferer from high-low blood pressure and hypertension.

(iv) Bone problems - Majority of the respondents had problems of Rheumatism, joint pain, back-ache and non-sensation in feet.

(v) Skin problems - So far as skin problems of respondents were concerned, majority of respondents were sufferer of Axima, itching (scabies) and swelling problems.

(vi) Other physical problems- There were some other physical problems from which elderly women were suffering. Majority of them had the problem impaired hearing, Diabetese and Asthma.

3 (A). ROLE OF FAMILY IN RELATION TO ELDERLY WOMEN

(i) About sleeping arrangement of respondents - So far as the sleeping arrangement of respondents were concerned, majority of the respondents had not separate room. As regards to separate bed, majority of the respondents had separate bed.

Majority of the respondent's clothes were not regularly washed by the family members and the findings related to cleaning of room, majority of the respondent's room was not regularly washed by the family.

(ii) Frequency of food served - Majority of the respondents were getting food two times in a day.

(iii) Quantity of food- So far as the quantity of food provided to the elderly women was concerned, majority of the respondents were getting food as per their need.

(iv) Nutrients in the diet- Nutritious diet is the requirement of old age. the findings revealed that majority of the respondents were not getting milk, fruits, paneer and meat in their diet.

(v) Quality of food - Majority of respondent's families were provided normal quality food to the elderly women of their family.

(vi) Treatment seeking behaviour- So far as the treatment seeking behaviour of respondents was concerned ,majority of the

respondents were seek treatment when they were at the stage of serious pain.

(vii) Treatment- Majority of the respondent's families preferred government hospitals for the treatment of elderly women of their family.

(viii) Condition of health check-ups and supply of drugs-
Majority of the families didn't properly taken care of the respondents, 43.67% of the families sometimes taken care for health check-ups and drugs to respondents.

(xi) Entertainment provided to the respondents- Entertainment facilities to the olds is one of the important role of family, the findings showed that majority of the respondents had not facility of televisions, radio, tape listening. Majority of the respondents were never enjoyed facility of taken participation in religious seminars.

(x) Family emotional behaviour- So far as the emotional behaviour of family in relation to elderly women was concerned, majority of the respondents' sons and their wives never associate with respondents and the family members were never considered needs of elderly women and nor given them adequate care. Majority of the respondents' grandsons were sometimes liked to associate with them.

(xi) Religious function- Majority of the respondents were sometimes taken to visit the temples by the family.

So far as outing facility was concerned, majority of the respondents were never gone for outing such as places like pilgrimages.

Majority of the respondents were sometimes given opportunity to listen katha/Bhagwat ceremonies and not to ever.

3 (B). SELF CARE PRACTICES BY THE ELDERLY WOMEN

(i) Self care practices - so far as the self care practices performed by the respondents were concerned, majority of the respondents were sometimes go for walk. Majority of the respondents 63.67% were never practicing Yoga.

As regards to health check-ups practices, majority of the respondents were some times go for their health check-up and majority of them were bring their medicine some times.

(ii) Self hygenic activities - Majority of the respondents were capable of performing hygenic activies such as bathing, washing clothes, combing and nail cutting.

(iii) Preventive self measures for diseases - So far as the preventive self measures taken by the respondents were concerned, majority of the respondents did not take care for good food taking, exercise, personal hygiene, clean environment, clean home and preventive vaccination and medicines to avoid themselves from diseases.

4. ISSUES RELATED TO AGED

Various issues in relation to the old age were also studied in this research study. The summary of which is as follows :-

(i) Self observed issues - Majority of the respondents were facing isolation, loneliness, unrespect, feeling of socially unfit, lack of systemised planning for future and occupationally uninvolvement in their lives.

(ii) Issues before Voluntary Organization / Non Government Organization- The majority of the respondents said that 'training problems of rehabilitation' as well as providing elders a 'respectful role', 'planning of welfare schemes' through their participation, 'organising workshop' for retirement schemes and lastly formulation of respectful environment for elders, were major issues before Voluntary Organization and Non-Government-Organizations.

(iii) Issues before Social Organization- So far as the elderly related issues before social organisation were concerned, the majority of the respondents accepted that there was various issues related to implementation of programmes in the area such as identification of real and essential needs of elders, fulfilment of finance responsibilities, to aware citizens about problems of elders, as well as service them like (PITRARIN), establish day care homes and special homes, providing nurses to the elders to keep them please and assess capabilities and abilities about promotion of services.

(iv) Issues before Physicians- As regards issues before physicians in relation to care of aged, the majority of the respondents were told that (a) olds were pessimistic (b) untrained medical officers in geriatrics and (c) doctors' psycho inefficiency about elders care were the considerable issues.

(v) Issues before Families- So far as the issues of care of elders by their family members was concerned, the majority of the respondents were told that (a) lack of emotional care within the family related to aged, (b) carelessness of families about advises of physicians and majority of them answered that their family members were not (c) helping in their physical impairments at one side.

Majority of the respondents were told that (a) lack of emotional stability, (b) ignoring elderly members in family decision-making process, (c) lack of financial aid for aged (d) lack of medical aid-nutrition and care were the great issues on the other hand.

(vi) Issues before Government- So far as the issue in relation to elders before government, the majority of the respondents were told that (a) formulation of experts group for promotion in life quality of elders, (b) identification of overall problem for elders (c) formulation of national policy and its implementation, (d) old age pension and other facilities, (e) essential care of olds, (f) establishment of old homes/care centres and counselling centres are important issues before government.

(vii) Issues related to medical care and services for aged-

Majority of the respondents were answered that (a) lack of separate geriatric deptt. is Distt. hospital (b) specialization in geriatrics and non-utilisation of elders experience in their care and lack of research on geriatrics were also one of the important issue.

(viii) Other issues related to aged- Majority of respondents were agreed that (a) outside service of sons, (d) disliking opinion of olds by the youngers and (c) change in the size of family were those issues which effect care of olds.

5. OPINION OF RESPONDENT ABOUT OLD AGE WELFARE PROGRAMMES

To study the opinion of the elderly women in relation to following social work, social services and social welfare measures provided by the Government and Non-Government- Organisation. The findings of the study is given below :-

(i) 25% concession in railways- As regard to 25% concession in railways travelling, majority of the respondents were having affirmative opinions.

(ii) Old age pension scheme- So far as opinion of the respondents in relation to old age pension scheme, the majority of 57.33% respondents had affirmative views.

(iii) Old age homes- Majority of the elderly women were having positive opinion in relation to old age homes.

(iv) Day care centers- Majority of respondents 42.33% had good views about day care centres.

(v) Standard deduction of Rs 15.000/- So far as the opinion of respondents in regard to standard deduction of Rs. 15.000 was concerned majority of the respondent was indefinite about it.

(vi) Mobile medical care scheme- This scheme is running for aged, the majority of the respondents were having indefinite views about this scheme.

(vii) Pension scheme- Majority of the respondents were having favourable opinion in relation to pension scheme.

(viii) Senior citizens saving scheme- The majority of elderly women were having positive opinion about senior citizens saving scheme.

(xi) Maintenance Act (Code of Criminal Procedure,1973)- In the law, Maintenance Act, which favours maintenance of elderly, and in this regard 43.33% majority of the respondents had positive views.

6. LIMITATIONS OF STUDY

The above conclusions need to be considered in the light of the following restrictions and limitations of study.

(i) The present study was based on 300 elderly women residing

in urban area of Jhansi city. Though 300 elderly women were randomly selected out of the total elderly women available in research area of urban Jhansi. Only this could be possible considering the time and resources available. The above study sample was somewhat small in size. Due to this reason, results of the study can be taken to be true for the community studied only. However, these results can also be taken to be true in other urban areas, with similar socio-economic backgrounds and with respondents resembling on different other aspects.

(ii) The analysis of data presented in different tables, though every care and precaution were taken during data collection and their analysis, however, possibility of interviewer's bias during the conduct of the interviews and of non-sampling errors during data collection as well as in their analysis, can not be ruled-out.

SUGGESTIONS

In the light of findings observed in the study and conclusions drawn subsequently, the following suggestions / recommendations are brought fourth for the area study.

- ◆ There is an urgent need to bring about a greater awareness of physical, social, psychological, economical and other problems of the elderly among all strata of the population. The ageing process should be identified early to minimize and delay the chronicity and reduce the dependency by the aged on the family and society. Providing shelter in old age home and charities are not enough. The concept of long term care has to be developed.
- ◆ There is an urgent need to establish the comprehensive social security system which also covered the unorganized sector so that the elderly at the sun set of their life can be able to lead respectful and happiest life in the society. The people should systematically plan their life so that they are left with sufficient money to cater to their old age needs.
- ◆ There is need for better understanding of the various facts of the intelligence of the aged by the young people so that they can get rid of their traditional stereotypes and cash on the experience of old for their benefits. This will give old people a sense of participation and meaning in life besides providing right direction to the young and inexperienced people. Knowledge and experience of elderly should be more actively utilized and they should be involved in income

generating scheme. Various subsidies, concessions and facilities should be provided to them.

◆ The employment opportunity should be provided on the rural area from where the large number of young generations are migrating to the urban areas leaving their aged parents on the mercy of God.

◆ Community homes for the destitute elderly should be established and subsidized food and other essentials should be extended in the elderly who belonged to weaker sections of the populations. Old age pension should be raised reasonably.

◆ Counseling regarding their old age problems should be provided to the elderly people and family so that they can better understand their problem, which can also help especially to elderly people to check their over reaction to their problems.

◆ There is a serious lack of geriatric specialities and health institutions specifically for geriatric patients. We should have separate geriatric wards and departments for the elderly. Public health centres should take care of the requirements of the aged.

◆ Economically backward elderly persons should be provided with subsidized or free dentures, spectacles, hearing aids, wheel chairs or orthopaedic appliances and dietary supplements.

◆ Giving sufficient employment opportunities to the women so

that they can achieve self sufficiency at the age of 60 and above.

- ◆ The attitude towards aged widows needs to be changed for improving their status in the society.
- ◆ To consideration of the aged as asset, valuable resource and pramote the utilisation of their potential in community development and in organising themselves as well as to strengthen family care of the aged by organising additional support from the community and family ties should be strengthened by IEC (information, education and communication) programmes so that senior citizens occupy a better place in the family.
- ◆ There is need to start economic supportive programmes for the aged. (e.g. cottage and small -scale industry). Vocational rehabilitation centres may be started to help the disabled to meet their basic needs.
- ◆ There is need of nation -wide mass awareness campaign directed to general population highlighting the established pattern of maintaining and taking care of elderly parents on the millennium old tradition by the present generation and that this is the care of the one who brought them up to the present stage.
- ◆ To encourage greater participation of non-government organisation in the care of the aged particularly in providing day care centres and facilities in deprived areas and slums.
- ◆ To identify and focus on the aged as a vulnerable group.
- ◆ To promote schemes of social security for the elderly people, especially those in the unorganised sector.

KEY CONCEPTS

- (1) **Elderly** - Persons advanced in age i.e. 60+
- (2) **Earner dependent** - Who were earner but dependent upon other family members.
- (3) **Partially dependent** - Small expenditure is borne by herself and for big expenditure has to depend upon earner of family.
- (4) **Geriatrics**- Science which deals ageing, medical and health problems of oldmen.
- (5) **Attitude towards life** - The feeling of aged towards life whether they feel happy or unhappy
- (6) **Myths**- Story handed down from very ancient times (misconception)
- (7) **VHA** - Voluntary Health Association
- (8) **N.G.O.** - Non-Governmental- Organisation
- (9) **Indicator of ageing** - measurements such as listening, visual and physical appearance, rate of morbids.
- (10) **Ageing** - condition of human life after 60+.
- (11) **Rehabilitation** - restoration to former state.
- (12) **Dementia** - Impaired memory
- (13) **Obstinacy** - Willfullness.

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साक्षात्कार - अनुसूचि
वृद्ध महिलाओं की प्रस्थिति उवं समस्याएँ
(झाँसी नगर के विशेष संदर्भ में)

नाम :

दिनांक

उत्तरदाता का नाम :

उत्तरदाता का पता :

उत्तरदाता की आयु :

(i) 60-65

(ii) 65 - 70

(iii) 70 - 75

(iv) 75-80

(v) 80 से अधिक

जाति -

(i) सामान्य

(ii) पिछड़ी

(iii) दलित

शैक्षिक स्तर -

(i) अशिक्षित

(ii) प्राइमरी

(iii) जू. हा. स्कूल

(iv) हाईस्कूल

(v) इण्टर

(vi) स्नातक

(vii) परास्नातक

(viii) अधिक

मुख्य व्यवसाय -

(i) कृषि

(ii) श्रमिक

(iii) बेकार

(iv) प्राइवेट नौकरी

(v) रिटायर्ड

परिवार की मासिक आय -

(i) 1000 से कम

(ii) 1001 - 1500

(iii) 1501 - 2000

(iv) 2001 - 2500

(v) 2501 - 3000

(vi) 3001 - 3500

(vii) 3501 - अधिक

वैवाहिक स्थिति-

(i) अविवाहित

(ii) विवाहित

(iii) विधवा

(vi) तलाकशुदा

(v) पृथक

परिवार का आकार :

(i) एकाकी

(ii) संयुक्त

(iii) विस्तृत

10. आपका घर कैसा है ?

(i) कच्चा

(ii) पक्का

(iii) अर्धपक्का

11. मकान की स्थिति :

(i) नल

(ii) विद्युत

(iii) स्नानगृह

(iv) रसोईगृह

(v) ऊँगन

	हाँ	नहीं	अनुत्तर		
उत्तर दाताओं के सामाजिक स्तर सम्बंधी सूचनाएँ -					
(i) क्या आपकी समाज में पूछ होती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) क्या आप सामाजिक कार्यक्रमों में भाग लेती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) क्या आपको अपने बच्चों से सम्मान मिलता है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iv) क्या बिरादरी से आपके नाम पर निमंत्रण पत्र आते हैं ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(v) क्या आप अपने मित्रों के यहाँ आती जाती हैं ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
उत्तर दाताओं की विभिन्न सामाजिक संगठनों में सदस्यता सम्बंधी सूचनाएँ -					
(i) क्या आप किसी सामाजिक संगठन की सदस्या है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) क्या आप किसी सांस्कृतिक संगठन की सदस्या है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) क्या आप किसी धार्मिक संगठन की सदस्या है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
आपके परिवार के अन्य सदस्यों के साथ अन्तः वैयक्तिक संबंध कैसे हैं ?					
(i) अत्यन्त कष्टकारी	<input type="checkbox"/>	(ii) कष्टकारी	<input type="checkbox"/>	(iii) मैत्रीपूर्ण / हार्दिक	<input type="checkbox"/>
(iv) सन्तोषजनक	<input type="checkbox"/>				
परिवार द्वारा आपको किस प्रकार स्वीकारा जाता है ?					
(i) प्रेम / अभिन्नदन के साथ	<input type="checkbox"/>	(ii) सहन करना	<input type="checkbox"/>	(iii) अवांछनीय / फालतू	<input type="checkbox"/>
(iv) कोई उत्तर नहीं	<input type="checkbox"/>				
आपका आर्थिक स्तर क्या है ?					
(i) कमाऊ	<input type="checkbox"/>	(ii) आश्रित	<input type="checkbox"/>	(iii) कमाऊ पर आश्रित	<input type="checkbox"/>
आप किसके साथ रह रही है ?					
(i) अकेले	<input type="checkbox"/>	(ii) पति के साथ	<input type="checkbox"/>	(iii) पति एवं बच्चों के साथ	<input type="checkbox"/>
(iv) बच्चों के साथ	<input type="checkbox"/>	(v) नाती-पोतोंके साथ	<input type="checkbox"/>	(vi) रिश्तेदारों के साथ	<input type="checkbox"/>
आपको निम्न में से किसमें वैयक्तिक स्वतंत्रता है :-					
(i) निर्णय लेने में	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) परिवार नियंत्रण में	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) स्वयं की रुचियों को पूर्ण करने में	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iv) व्यक्तिगत मामलों में	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
उत्तरदाता की आर्थिक स्तर सम्बंधी सूचनाएँ :-					
(i) क्या मकान आपके नाम है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) क्या आपका बैंक में खाता है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) क्या आपके नाम पर कोई जमीन है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

आपके तनाव ग्रसित रहने के कौन कौन से कारण हैं ?

(vi) पुत्र व उसकी पत्नी के मध्य झगड़े

(vii) पुत्र का शराबी होना

(viii) पुत्र का जुआरी होना

(ix) बच्चों की अनुशासनहीनता

आप निम्न में से किन नेत्र संबंधी समस्याओं से पीड़ित हैं—

(i) क्या आपको मोतियाबिन्द है ?

(ii) क्या आप दूर-दृष्टि से पीडित हैं?

(iii) क्या आप समीप - दृष्टि से पीड़ित हैं ?

(iv) क्या आप रत्नौंधी से पीड़ित हैं ?

आपको निम्न से कौन – सी पाचन सम्बंधी समस्यायें हैं:-

(i) क्या आप गैस रोग से पीड़ित हैं ?

(ii) क्या आपको मल त्याग में कष्ट होता है ?

(iii) क्या आपका खाना ठीक से नहीं पचता है ?

(iv) क्या आपको भूख भली – भाँति न लगने की परेशानी है ?

आपको निम्न में से

(i) उच्च रक्त चाप

(ii) निम्न रक्त चाप

(iii) उच्च / निम्न रक्त चाप

(iv) हृदय सम्बंधी शिकायत

आप निम्न में से किन अस्थि (हड्डी) सम्बन्धित हैं?

(i) क्या आप गठिया रोग से पीड़ित हैं ?

(ii) क्या आपके जोड़ों में दर्द रहता है ?

(iii) क्या आपकी रीढ़ की हड्डी में ददृ हैं?

आप निम्न में से किन त्वचा संबंधी समस्याओं से पीड़ित हैं:-

- (i) क्या आपको दाद की शिकायत है ?
- (ii) क्या आपको खाज की शिकायत है ?
- (iii) क्या आपकी त्वचा में कहीं सूजन है ?

आप निम्न में से किन अन्य शारीरिक समस्याओं से पीड़ित हैं:-

- (i) क्या आपको कम सुनाई पड़ता है ?
- (ii) क्या आप मधुमेह से पीड़ित है ?
- (iii) क्या आप साँस रोग (अस्थमा) से पीड़ित है ?
- (iv) क्या आप क्षयरोग से पीड़ित है ?

परिवार द्वारा वृद्धों को आवासीय सुविधायें प्रदान करने सम्बंधी कार्य : हाँ नहीं अनुत्तर

- (i) अलग से कमरा
- (ii) अलग से बिस्तर
- (iii) ओढ़ने – बिछाने के वस्त्रों की नियमित सफाई
- (iv) कमरे की प्रतिदिन सफाई

आपको भोजन कितनी बार प्रदान किया जाता है ?

- (i) एक बार
-
- (ii) दो बार
-
- (iii) तीन बार
-

आपको किस मात्रा में भोजन दिया जाता है ?

- (i) थोड़ा
-
- (ii) पर्याप्त
-
- (iii) सामान्य
-

आपके भोजन में निम्न में से कौन से पोषक तत्व होते हैं ?

- (i) दूध
-
- (ii) हरी सब्जियाँ
-
- (iii) फल
-

- (iv) पनीर
-
- (v) मीट
-

आपको दिये जाने वाले भोजन को आप कैसा मानती हैं ?

- (i) उत्तम
-
- (ii) सामान्य
-
- (iii) निम्न
-

परिवार द्वारा वृद्धों को स्वास्थ्य सेवायें प्रदान करने सम्बंधी कार्य –

- (i) थोड़ी सी तकलीफ होने पर
-
- (ii) चलने – फिरने में रुकावट आने पर
-
- (iii) अत्याधिक कष्ट होने पर
-
- (iv) कोई ध्यान नहीं देता
-

परिवारीजन आपका कैसा इलाज करवाना पसंद करते हैं ?

- (i) प्राइवेट अस्पताल में
-
- (ii) सरकारी अस्पताल में
-
- (iii) घरेलू इलाज
-

- (iv) हाकिम (वैद्य) द्वारा
-

आपकी स्वास्थ्य जाँच करवाने तथा दवा प्रदान करने की क्या स्थिति है ?					
(i) नियमत	<input type="checkbox"/>	(ii) कभी - कभी	<input type="checkbox"/>	(iii) अनियमित	<input type="checkbox"/>
परिवार द्वारा प्रदत्त मनोरंजन सम्बंधी कार्य -			हाँ	नहीं	
(i) टी.वी.	<input type="checkbox"/>				
(ii) रेडियो	<input type="checkbox"/>				
(iii) टेप	<input type="checkbox"/>				
(iv) सत्संगों में ले जाना	<input type="checkbox"/>				
आपके और परिवार के मध्य किस तरह का रिश्ता है ?			हमेशा	कभी कभी	कभी नहीं
(i) क्या बेटा - बहू आपके पास बैठते हैं ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) क्या आपकी आवश्यकताओं का ध्यान रखा जाता है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) क्या आपकी भली - भाँति देखरेख की जाती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iv) क्या नाती-पोते आपके साथ समय व्यतीत करना पसंद करते हैं ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
क्या आपके परिवारीजन निम्न धार्मिक संस्कारों में आपको सहभागिता प्रदान कराते हैं ?					
(i) मंदिर दर्शन हेतु	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) गत पाँच वर्षों में घर से	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
बाहर तीर्थस्थल के दर्शन हेतु	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) जागरण / कथा भागवत के श्रवण हेतु	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
उत्तरदाताओं के द्वारा स्वयं किये जाने वाले कार्यों का विवरण :-			हाँ	कभी नहीं	कभी कभी
(i) क्या आप नित्य धूमने जाती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) क्या आप योग क्रियायें करती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) क्या आप स्वयं स्वास्थ्य जाँच के लिये जाती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iv) क्या आप अपनी दवाई स्वयं ले आती है ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
क्या आप निम्न व्यक्तिगत स्वच्छता स्वयं कर लेती है ?			हमेशा	कभी नहीं	कभी कभी
(i) स्नान	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) कपड़े धोना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iii) कंघी करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(iv) नाखून काटना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
आप रोग से बचाव के लिये क्या - क्या उपाय प्रयोग में लाती है ?			हाँ	नहीं	
(i) अच्छा खाना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
(ii) व्यायाम	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

(iii) व्यक्तिगत स्वच्छता	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iv) साफ वातावरण	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(v) साफ घर	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(vi) दवाईयाँ	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
निम्न में से कौन सी स्वयं वृद्धों के सम्मुख मुद्दे हैं—			हाँ	नहीं
(i) उनकी पृथकता, अकेलापन, उदासीनता	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(ii) उनकों सम्मान व उचित देखरेख के साथ स्वीकारा ना जाना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iii) समुदाय हेतु अनुपयोगी अनुभव करना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iv) सेवानिवृत्ति के पश्चात् व्यवस्थित योजना ना होना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(v) व्यावसायिक तौर पर व्यस्त ना होना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
निम्न में से कौन सी परिवार के सम्मुख वृद्धों से संबंधित समस्याएँ हैं ?			हाँ	नहीं
(i) भावात्मक दृढ़ता का अभाव	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(ii) वृद्धों की पृथकता / अकेलापन और उपेक्षा का भाव कम करने की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iii) पारिवारिक संबंधों के निर्णयों में उन्हें सहभागी न बनाना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iv) वृद्धों को वित्तीय सहायता का अभाव	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(v) वृद्धों को चिकित्सकीय सहायता — उपयुक्त पोषण— औषधि तथा देखभाल सुनिश्चित करने की समस्या।	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
निम्न में से कौन सी वृद्धों की देखभाल से सम्बंधित मुद्दे हैं —			हाँ	नहीं
(i) भावात्मक देखरेख का अभाव	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(ii) मनोवैज्ञानिक देखरेख का अभाव	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iii) डॉक्टर के निर्देशों का परिवार द्वारा पालन न होना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iv) उनके कम सुनने — देखने व चलने में सहायता न करना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
निम्न में से कौन से सरकार के समक्ष वृद्धों के कल्याण व पुर्नवास से सम्बंधित मुद्दे हैं—			हाँ	नहीं
(i) वृद्धों की जीवन गुणवत्ता में प्रोन्नति हेतु विशेषज्ञों व निपुणजनों का समूह गठित करना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(ii) वृद्धों की समस्त समस्याओं के आयाम का पता लगाना	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iii) वृद्धों से सम्बन्धित राष्ट्रीय नीति निर्धारण व क्रियान्वयन की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(iv) वृद्धों को वृद्धावस्था पेंशन व अन्य लाभप्रद सुविधायें देने की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(v) वृद्धों को अनिवार्य देखरेख प्रदान करने की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं
(vi) विशेष वृद्ध गृह / डे केयर केन्द्रों के निर्माण की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	हाँ	नहीं

	हाँ	नहीं	अनुत्तर
(vii) परामर्श केन्द्रों की स्थापना की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
क्या स्वैच्छिक/गैरसरकारी संगठनों के समुख वृद्धों के सम्बंध में निम्न मुद्दे हैं:-			
(i) वृद्धों के पुर्नवास हेतु प्रशिक्षण की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) उन्हे सम्माननीय कार्य प्रदान करने के लिये कार्यक्रमों की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) वृद्धों से मिलकर कल्याण की योजनाओं का नियोजन करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) सेवानिवृत्ति की योजना की जानकारी हेतु कार्यशालाओं का आयोजन करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) समाज में वृद्धों हेतु सम्मानीय प्रस्थिति निर्मित करना।	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
निम्न में से कौन से सामाजिक संगठनों के समक्ष मुद्दे हैं:-			
(i) वृद्धों हेतु उनके ही क्षेत्र में कार्यक्रमों का क्रियान्वयन करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) बैठकों द्वारा वृद्धों की वास्तविक/अनिवार्य आवश्यकताओं की पहचान करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) वृद्धों के वित्तीय उत्तरदायित्वों की पूर्ति करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) नागरिकों को वृद्धों की समस्याओं से जागरूक करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(v) पितृ ऋण के रूप में उनकी सेवा करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vi) वृद्धों हेतु विशेष गृहो/दिन में देखभाल करने वाली संस्थाओं की स्थापना करना।	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(vii) वृद्धों को प्रसन्नचित रखने हेतु सेविकाएँ प्रदान करना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(viii) वृद्धों की देखभाल की प्रोन्ति हेतु क्षमताओं/योग्यताओं की समीक्षा करना।	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
निम्न में से कौन से वृद्धों से सम्बंध में फिजीशियन के समुख मुद्दे हैं -			
(i) वृद्ध अधिकांशतः निराशावादी होते हैं ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) प्राथमिक चिकित्साधिकारियों का वृद्धों के उपचार के लिये अपशिष्ट होना	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) वृद्धों की प्राथमिक देखरेख में मनोवैज्ञानिक रूप से डॉक्टरों का अद्द्ध होना।	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
निम्न में से कौन से वृद्धों की चिकित्सकीय देखभाल व सेवा सम्बंधी मुद्दे हैं:-			
(i) जनपदीय चिकित्सालयों में अलग से वृद्ध क्लीनिकों का अभाव	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(ii) चिकित्सा में परासनातक स्तर पर वृद्धावस्था में विशेषज्ञता की शिक्षा की समस्या	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iii) वृद्धों की स्वयं के पुर्नवास में उनकी कार्य योग्यता में वृद्धि के लिये उनके ही अनुभवों को प्रयोग करने के मुद्दे	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(iv) वृद्धावस्था के चिकित्सा उपचार के ऊपर अनुसंधान संबंधी मुद्दे	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

निम्न में से कौन से वृद्धों से सम्बंधित अन्य मुद्दे हैं—

(i) क्या पुत्रों का घर से बाहर नौकरी करना माता पिता की देखरेख में उनकी असमर्थता व्यक्त करता है ?

(ii) क्या युवा पीढ़ी वृद्धों के अनुभवों का लाभ लेना पसंद नहीं करती है ?

(iii) क्या परिवार के आकार में परिवर्तन होने से वृद्धों की देखभाल पर विपरीत प्रभाव पड़ता है ?

वृद्धों को रेलयात्रा व्यय में दी जाने वाली 25 प्रतिशत छूट के संबंध में आपकी क्या राय है ?

वृद्धावस्था पेंशन के संबंध में आपकी क्या राय है ?

वृद्धों के बारे में आपके क्या विचार हैं ?

वृद्धों की देखरेख हेतु स्थापित डे केयर केन्द्रों के प्रति आपकी क्या राय है ?

सीनियर सिटीजन्स को स्टैण्डर्ड टैक्स डिडक्षन के अतिरिक्त 15000/- रु. की आयकर अतिरिक्त छूट प्रदान की जाती है इसके संबंध में आपके क्या विचार हैं ?

वृद्धों हेतु चलायी जा रही है सचल चिकित्सकीय देखरेख के बारे में आपके क्या विचार हैं ?

सेवानिवृत्त शासकीय एवं अर्द्धशासकीय कर्मचारियों की पेंशन के सम्बन्ध में आपकी क्या राय है ?

डाकखाने द्वारा चलायी जा रही वरिष्ठ नागरिक बचत योजना के सम्बंध में आपके क्या विचार हैं ?

वृद्धों के भरण पोषण सम्बंधी अधिनियम (कोड ऑफ क्रिमिनल प्रोसीजर, 1973) के बारे में आपकी कैसी राय है ?

सहमत

असहमत

अनिश्चित

सकारात्मक

नकारात्मक

तटस्थ

अच्छी

बुरी

सामान्य

सहमत

असहमत

अनिश्चित

सकारात्मक

नकारात्मक

तटस्थ

शोधार्थी के हस्ताक्षर

(प्रतिभा सिंह)

शोधार्थी